Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Nulojix® (belatacept) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:			Patient's Phone:		
Patient Name:			Address:		
Date of Birth:			City, State, Zip:		
Height in inches:	Weight: LB or KG		Gender:	Allergies: ☐ See list ☐ NKDA	

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐ Z94.0 - Kidney Transplant Status

☐ _____ - Other:

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent H&P and Medication list	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Tried and failed therapies		NEXT INFUSION DATE:
4	**REQUIRED:** EBV serology for new start patients		**IF ORDER CHANGE:**
5	**REQUIRED:** TB results for new start patients		☐ **Continue current order until insurance approved**
6	Lab results, transplant summary note, and/or tests to support diagnosis.		
7	☐ Basiliximab induction used at time of transplant (prescriber designation required)		

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive belatacept if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new-onset or deterioration neurological changes, and/or surgery

Required for weight based dosing: Transplant date:_____ Patient Transplant weight: _____

(Dose is calculated on transplant weight unless weight varies by > 10%, after which they will be dosed on actual body weight)

☐ Check here if dosage is to be calculated based on actual body weight

DOSE/FREQUENCY:

From Transplant:

☐ **Initial Phase:** Nulojix® (belatacept) 10mg/kg in 250mL NS IV over 30 minutes

1st dose to be administered by PIS ____ days post transplant. Remainder of initial phase to be given per manufacturer reccomendations. (*Intial phase post transplant: day 5, week 2, week 4, week 8, week 12*)

☐ **Maintenance Phase:** Nulojix® 5mg/kg in 100 ml NS IV to infuse over 30 minutes every 4 weeks

Conversion from Calcineurin Inhibitor:

☐ **Initial Phase:** Nulojix® (belatacept) 5mg/kg in 100mL NS IV over 30 minutes every 2 weeks x 5 doses (*On days 1, 15, 29, 43, 57*)

☐ **Maintenance Phase:** Nulojix® (belatacept) 5mg/kg in 100 mL NS IV to infuse over 30 minutes every 4 weeks

☐ Other: _____

SPECIAL/LAB ORDERS:

☐ _____

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:	ADVERSE REACTION & ANAPHYLAXIS ORDERS:
☑ Start PIV/Access CVC ☑ Flush device per facility standard flushing procedure ☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	

Palmetto INFUSION

Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- [ ] **Patient demographics - address, phone number, SS#, etc.**
- [ ] **Insurance information - copy of the card(s) if possible**
- [ ] **Plan of Treatment/Orders**
- [ ] **Most recent physician office notes to include tried and failed therapies - all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- [ ] **Any lab results or other diagnostic procedures to support the diagnosis.**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com