NULOJIX (BELATACEPT)
Infusion Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: ______________________ **DOB:** __________ **Phone:** __________

Patient Status: New to Therapy Continuing Therapy **Next Treatment Date:** __________

Medical Information

Diagnosis: Kidney transplant Other ______________________

ICD-10 Code: __________ **Allergies:** ______________________

Patient weight at time of transplantation: ______ lbs. (required)

Patient weight (current): ________ lbs.

Therapy Order

Dosing for Initial Phase and Initial Maintenance (10 mg/kg until week 12, then 5 mg/kg starting at week 16)

Nulojix _____ mg IV on Day 1 (day of transplantation, prior to transplantation) and day 5, at the end of weeks 2, 4 and 8, then week 12 after transplantation. Then, _____mg IV at the end of week 16 after transplantation and every 4 weeks (plus or minus 3 days) thereafter x1 year

Patient has received ______ doses thus far, next dose due on ________

Dosing for maintenance phase (5 mg/kg)

Nulojix _____ mg IV every 4 weeks x1 year

Other: ______________________

Prescribed doses must be evenly divisible by 12.5 mg

The total infusion dose of Nulojix should be based on the actual body weight of the patient at the time of transplantation and should not be modified during the course of the therapy, unless there is a change in the body weight of greater than 10%. If the patient has had a >10% weight change, please notify the physician for dose change recommendations.

Lab Orders: ______________________ **Frequency:** Every infusion Other __________

Yearly TB QFT screening (optional)

Required labs to be drawn by: Infusion Center Referring Provider

Other orders: ______________________

Provider Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: __________ **Signature:** __________ **Date:** __________

Provider NPI: __________ **Phone:** __________ **Fax:** __________ **Contact Person:** __________

Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): __________

Service Areas

Des Moines, IA West Des Moines, IA Chicago, IL Omaha, NE Buffalo, NY Dallas, TX

Phoenix, AZ Other __________

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COMPREHENSIVE SUPPORT FOR NULOJIX (BELATACEPT) THERAPY

Patient Information

Patient Name: ______________________ **DOB:** ______________________

Required Documentation for Referral Processing & Insurance Approval

Include signed and completed order (MD/prescriber to complete page 1)

Include patient demographic information and insurance information

Include patient's medication list

Supporting clinical notes (H&P) to support primary diagnosis

Will Nulojix be used in combination with basiliximab induction, mycophenolate mofetil and corticosteroids?

Yes No

Labs attached

Other Medical Necessity: ______________________

Required Information

TB screening test completed within 12 months – attach results

Positive **Negative**

EBV serostatus – attach results

Nulojix Distribution Program notification (855) 511-6180 – Patient ID#: ______________________

*If TB results are positive, please provide documentation of treatment or medical clearance and a negative CXR

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

HY-VEEHEALTHINFUSION.COM

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