Hy-Vee health INFUSION CARE

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 _____

HY-VEEHEALTHINFUSION.COM

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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.

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