MIC | METRO INFUSION CENTER

INFUSION ORDERS- NULOJIX (BELATACEPT)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS		
☐ New Referral	☐ Dose or Frequency Change	☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/

Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE	
☐ Kidney Transplant	ICD 10 Code: Z94.0
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes supporting primary diagnosis
☐ Patient demographics & insurance information	☐ Labs and Tests supporting primary diagnosis
☐ EBV serology	☐ See attached lab draw protocol
☐ Date of transplant	☐ Please include patient's Nulojix ID number assigned by the Nulojix Distribution Program
☐ See attached infusion dosing protocol	
List Tried & Failed Therapies, including duration of treatment: 1) 2)	

MEDICATION ORDERS	
Please indicate dose and frequency in blank space as appropriate. If specific dates are requested, please include also. *Clinic RNs: please round all weight-based doses to nearest 12.5mg.*	
Initial Dosing	☐ Nulojix 10mg/kg IV _____ ☐ Nulojix _____mg IV _____
Maintenance Dosing	☐ Nulojix 5mg/kg IV _____ ☐ Nulojix _____ mg IV _____
Refills: ☐ X 6 months ☐ X 1 year ☐ _____ doses	
Patient Weight at time of Nulojix initiation: _____ Clinic RNs: notify referring MD office immediately if the patient's weight *on the day of infusion* ***differs by 10%*** from initial weight listed here.	

PHYSICIAN INFORMATION		
Prescribing Physician:		
Office Phone:	Office Fax:	Office Email:
Physician Signature:		Date:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.
Contact us with questions at: (877) 448-3627
Fax Completed Form and all documentation to: 866-507-1164