

ORDERING OFFICE, ALSO FAX:

- Most recent labs
- Supporting clinicals / Recent H&P
- Insurance card, front and back

Belatacept (Nulojix)

Provider Order Form

Date:	Patient Name:	DOB:
ICD-10 code (required):		
ICD-10 description:		
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	
Ordering Provider:	Provider NPI:	
Referring Practice Name:	Phone:	Fax:
Practice Address:	City:	State: Zip Code:
NURSING		
<input checked="" type="checkbox"/> Provide nursing care per IVX Standard Nursing Procedures, including reaction management		
LABORATORY ORDERS		
<input type="checkbox"/> CBC	<input type="checkbox"/> every other dose	<input type="checkbox"/> every _____
<input type="checkbox"/> CMP	<input type="checkbox"/> every other dose	<input type="checkbox"/> every _____
<input type="checkbox"/> CRP	<input type="checkbox"/> every other dose	<input type="checkbox"/> every _____
<input type="checkbox"/> Other:		
PRE-MEDICATION ORDERS (ADMINISTER 30 MINUTES PRIOR TO PROCEDURE)		
<input type="checkbox"/> acetaminophen (Tylenol) <input type="checkbox"/> 500mg / <input type="checkbox"/> 650mg / <input type="checkbox"/> 1000mg PO		
<input type="checkbox"/> cetirizine (Zyrtec) 10mg PO		
<input type="checkbox"/> loratadine (Claritin) 10mg PO		
<input type="checkbox"/> diphenhydramine (Benadryl) <input type="checkbox"/> 25mg / <input type="checkbox"/> 50mg <input type="checkbox"/> PO / <input type="checkbox"/> IV		
<input type="checkbox"/> methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg / <input type="checkbox"/> 125mg IV		
<input type="checkbox"/> Other:		
Dose:	Route:	Frequency:
INFUSION THERAPY		
<input checked="" type="checkbox"/> belatacept (Nulojix) in 0.9% sodium chloride, intravenous infusion, administer with 0.2-1.2 micron filter		
▪ <input type="checkbox"/> 10mg/kg Day 1, Day 5, end of week 2, 4, 8, and 12. (Please indicate if patient has received any previous infusions)		
▪ <input type="checkbox"/> 5mg/kg end of week 16 and every 4 weeks thereafter		
▪ Prescribed doses must be evenly divisible by 12.5mg		
▪ Final concentration should range from 2mg/ml to 10mg/ml		
▪ Administer over 30 minutes		
<input checked="" type="checkbox"/> Flush with 0.9% sodium chloride at the completion of infusion		
<input type="checkbox"/> Patient is required to stay for 30-minute observation post infusion		
<input type="checkbox"/> Patient is NOT required to stay for observation time		
<input type="checkbox"/> Refills: <input type="checkbox"/> Zero / <input type="checkbox"/> for 12 months / <input type="checkbox"/> _____ (if not indicated order will expire one year from date signed)		
GENERAL PLAN COMMUNICATION		
Special instructions/notes:		

Ordering Provider: Initial here _____ and proceed to the next page.

ADULT REACTION MANAGEMENT

- Observe for **hypersensitivity reaction:** Fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation
- If reaction occurs:
 - Stop infusion
 - Maintain/establish vascular access
 - Notify referring provider
 - Consider giving the following PRN
 1. Acetaminophen (Tylenol) 650mg PO **OR** _____mg for pain or fever > 38 C/100.4 F
 2. Diphenhydramine (Benadryl) 25-50mg in 10ml NS slow IV push for rash, itching, pruritis
 3. Ranitidine 25mg in 10ml NS slow IV push over 5 minutes (Consider if patient already given IV Benadryl)
 4. Ondansetron (Zofran) 4mg Slow IV push over 5 minutes for nausea or vomiting.
 5. Methylprednisolone (Solumedrol) 125mg **OR** _____mg slow IV push.
 6. Other _____
 - When symptoms resolve resume infusion at 50% previous rate and increase per manufacturer's guidelines
- Severe allergic/anaphylactic reaction:**
 - If symptoms are rapidly progressing or continuing after administration of prn medications above and signs symptoms of severe allergic/anaphylactic reaction (angioedema, swelling of the mouth, tongue, lips, or airway, dyspnea, bronchospasm with or without hypotension or hypertension.)
 1. Call 911
 2. Consider giving epinephrine (1:1000 strength) 0.3ml IM. May repeat every 5-15 minutes to a maximum of 3 doses.
 3. Treat hypotension with 500ml 0.9% sodium chloride bolus. Repeat as needed to maintain systolic BP >90.
 4. Have oxygen by nasal canula available and administer 2-15 liters, titrate to keep Spo2 >92%
 5. Have Automated External Defibrillator available
 6. Notify referring provider. If unable to reach referring provider, notify Local Medical Director.
 7. Discontinue treatment

*NULOJIX is contraindicated in transplant recipients who are Epstein-Barr virus (EBV) seronegative or with unknown EBV serostatus due to the risk of post-transplant lymphoproliferative disorder (PTLD), predominantly involving the central nervous system (CNS)

Patient Name

Patient Date of Birth

Provider Name (Print)

Provider Signature

Date

Designate the desired location and fax the order form to:

CALIFORNIA fax: (844) 889-0275 | ___San Mateo ___Fremont ___San Ramon ___TBD

ILLINOIS fax: (312) 253-7244 | ___Glenview ___Schaumburg ___TBD

KANSAS / MISSOURI fax: (844) 900-1292 | ___Overland Park, KS ___Lee's Summit, MO ___Briarcliff, MO ___TBD

OHIO fax: (844) 627-2675 | ___Dublin ___Pickerington ___TBD

PENNSYLVANIA fax: (844) 820-9641 | ___Malvern ___Bensalem ___Montgomeryville ___East Shore ___West Shore ___TBD

TENNESSEE fax: (844) 627-2518 | ___Brentwood ___Hendersonville ___TBD

