

PATIENT INFORMATION

PATIENT NAME: _____ PHONE: _____
DATE OF BIRTH: _____ SEX: M F HEIGHT: _____ WEIGHT: _____ LBS KG
ALLERGIES: _____ PREFERRED CLINIC: _____
REFERRAL STATUS: NEW REFERRAL ORDER CHANGE ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

Z94.0 Kidney Transplant Status
 ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

INSURANCE INFORMATION LIST OF MEDICATIONS TRIED & FAILED THERAPIES MOST RECENT HISTORY & PHYSICAL Negative TB Screening
 Epstein-Barr Virus Serology Results Transplant Summary Notes

MEDICATION ORDER

Transplant Weight*: _____ LBS KG Transplant Date: _____

*Dose calculated on transplant weight unless weight varies by > 10%

MAINTENANCE: Nulojix® (belatacept) 5mg/kg IV in 100ml NS over 30 minutes every 4 weeks
*Maintenance dosing scheduled 4 weeks from week 12 dose

OTHER: _____

REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Patient to be observed for 30 minutes following the first infusion. Administer per protocol.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ NPI #: _____

EMAIL: _____ PHONE: _____ FAX: _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ CONTACT NAME: _____
(IF APPLICABLE)

SIGNATURE: _____ DATE: _____
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN