



**Birmingham, AL**  
F: 205-271-9971

**Huntsville, AL**  
F: 256-417-6408

**Knoxville, TN**  
F: 865-934-0249

**Nashville, TN**  
F: 615-645-4791

**Chantilly, VA**  
F: 703-935-2061

**PREVIOUS ADMINISTRATION**

**Please provide the following information:** Last Infusion Date: \_\_\_\_\_ Next Infusion Date: \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ Is the patient Diabetic: Y N ICD-10 Code: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Primary Diagnosis:** \_\_\_\_\_ Kidney Transplant  
 \_\_\_\_\_ Other: \_\_\_\_\_

**Please attach the following:** 1. Clinical MD Notes, labs, test supporting primary diagnosis -Transplant summary note, Transplant Weight: \_\_\_\_\_ lbs, Epstein-Barr Virus (EBV) Serology Results, TB Screening Results 2. Medication list (including immuno-suppressant regimen)  
 3. Copy of the patient's Insurance Card 4. Nulojix Distribution Program (NDP) ID#: \_\_\_\_\_

**Physician Information**

Prescribing Physician: \_\_\_\_\_ Practice Name: \_\_\_\_\_  
 Practice Phone: \_\_\_\_\_ Practice Fax: \_\_\_\_\_  
 Email: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
 Co-managing Physician: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

**Medication Order**

**Medication: NULOJIX® (belatacept)**

**New Start:**

Administer Nulojix 10 mg/kg IV\* (\_\_\_\_\_ mg\*) on the end of Week 2, Week 4, Week 8 and Week 12.  
 \_\_\_\_\_ # Doses Authorized to begin the cycle on the end of Week \_\_\_\_\_ (Date: \_\_\_\_\_)

**Maintenance Dose:**

Administer Nulojix 5 mg/kg IV\* (\_\_\_\_\_ mg\*) every four weeks  
 \_\_\_\_\_ # Refills (Recommend 5 Refills) with next scheduled dose due: \_\_\_\_\_

\*Dosing should be in increments of 12.5 mg and dosing weight should be transplant weight, unless there is a change of greater than 10%

**Pre-Medication Orders:** \_\_\_\_\_

No pre-medications are recommended based on manufacturer guidelines.

**Adverse Drug Reaction Protocol:** Manage any adverse reaction that may occur per approved ADR Protocol.

**By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)**

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

\_\_\_\_\_  
 Physician's NPI# Physician's Address  
 \_\_\_\_\_  
 Prescriber's Signature Date