pharmacy SPECIALISTS

P: 877.217.3619 • F: 877.220.6086
pharmacy-specialists.com

BELATACEPT (Nulojix) Order Form

REQUIRED: Demographics & Most recent H&P, Clinical Notes, and Medication List

PATIENT INFORMATION

Patient Name		Date of Birth		Gender	☐ Male ☐ Female
Address					
Home Phone		Work Phone		Cell Phone	

INSURANCE INFORMATION: Please fax a copy of the insurance card(s) with this form (front and back)

MEDICAL INFORMATION

Weight (kg)		Height		Allergies	
Diagnosis				ICD-10	
Patient Status	☐ New to Therapy ☐ Continuing Therapy			Next Treatment Date	
Line Access	☐ Port ☐ PICC Other: _____			Lumens	☐ 1 ☐ 2 ☐ 3

THERAPY ORDER

Dosing for Initial Phase and Maintenance (10mg/kg until week 12, then 5mg/kg starting at week 16)

☐ **Initial Phase:**

- Nulojix _____ mg IV on Day 1 (day of transplant) and Day 5, at the end of week 2, week 4, week 8, and week 12 after transplant.
- Then _____ mg IV at the end of week 16 after transplant and every 4 weeks (plus or minus 3 days) thereafter x 1 year

☐ **Maintenance Phase:**

- Nulojix _____ mg IV every 4 weeks x 1 year

- Transplant Date _____
- Patient Weight at time of transplant _____ (kg)
- Prescribed doses will be rounded to be evenly divisible by 12.5mg.
- The total infusion dose of Nulojix should be based on the actual body weight of the patient at the time of transplant, 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, the physician will be notified for dose change recommendations.

Flush orders: Sodium Chloride 0.9% flush 5-10ml per protocol pre/post infusion

Lab Orders: ☐ Required Annual TB testing ☐ Other: _____

Labs to be drawn by: ☐ Home Health Nurse ☐ Referring Provider

PROVIDER INFORMATION

By signing this form and utilizing our services, the prescriber is authorizing *Pharmacy Specialists* and its employees to serve as their prior authorization and designated agent in dealing with medical and prescription insurance companies. The prescriber certifies that the use of the indicated treatment is medically necessary, and the prescriber will supervise the patient's treatment.

Prescriber Name		Signature		Date	
Prescriber NPI		Phone		Fax	Contact Person

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Patient Name

REQURIED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- ☐ Include signed and completed order
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes (H&P) to support primary diagnosis
- ☐ PICC/Central line placement confirmation (if applicable)
- ☐ Other medical necessity: _____

REQURIED INFORMATION

- ☐ TB screening test completed within 12 months - attach results ☐ Positive ☐ Negative
- ☐ EBV serostatus - attach result
- ☐ Nulojix Distribution Program
  - Patient MUST be enrolled in the Nulojix Distribution Program (NDP) and have a patient ID number from NDP.
  - Call 855-511-6180 to enroll patient.
  - Nulojix Distribution Program Patient ID#: _____ (REQUIRED FOR MEDICATION TO BE ORDERED)

REFERRAL AND INSURANCE APPROVAL PROCESS: Please submit a completed order form and all required documentation. *Pharmacy Specialists* will complete insurance verification and submit all required documentation to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. Financial responsibility will be reviewed with the patient. Any available co-pay assistance programs will be discussed with the patient as needed. Thank you for the referral.