REVITALIZE
INFUSION CENTER

Nulojix®

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis:

☐ Kidney Transplant ICD-10 Code: Z94.0___

☐ Other_____ ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis including:
  - Transplant summary note
  - Transplant Weight: _____ lbs
  - Medication List – including immunosuppressive regimen
- Relevant labs and tests including:
  - Epstein-Barr Virus (EBV) Serology Results
  - TB Screening Results
- Nulojix Distribution Program (NDP) ID Number:_____

Height: _____

Weight: _____

Nulojix® (belatacept) Orders:

☐ Initial Dose: Administer Nulojix 10 mg/kg (_____ mg*) at the end of Week 2, Week 4, Week 8 and Week 12 for a total of 4 doses with the first dose due:_____

☐ Maintenance Dose: Administer Nulojix 5 mg/kg (_____ mg*) intravenously every four weeks for 13 total doses with next scheduled dose to be due on:_____

☐ Other:_____

*Dosing should be in increments of 12.5 mg and based on transplant weight unless there is a change of >10%

Pre-Medication Orders: _____

*No pre-medications are recommended based on the manufacturer's PI

Labs:_____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus