NULOJIX INFUSION ORDER (BELATACEPT)

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LIVING YOUR BEST LIFE. ONE DROP AT A TIME.

Date: ____/____/_____

PATIENT INFORMATION

Patient Name:_____ DOB:___/____/____ Phone: _____

Height: _____ Weight (Required):_____ lbs/kg

Allergies: _____

MEDICAL INFORMATION

ICD-10 & Diagnosis:

- ☐ Z48.22: Kidney transplant aftercare
- ☐ Z94.0: Kidney Transplant
- ☐ Z79.62: Long-Term (Current) use of immunosuppressants
- ☐ Other : _____

NULOJIX THERAPY ORDER

- ☐ Nulojix 10mg/kg till week 12, then 5mg/kg from week 16 every 4 weeks x 1 Year
- ☐ Nulojix 5mg/kg IV every 4 weeks x 1 Year
- ☐ Other Doasge: _____

Start Date of Infusion: ___/___/___ End Date: ___/___/___

PROVIDER INFORMATION

Provider's Name: _____

Provider's NPI: _____ Signature: _____

Phone: _____ Fax: _____ Date: _____/_____/_____

Office Address: _____

Email Address: _____ Contact Person: _____

PLEASE FAX COMPLETED FORM, CLINICAL DOCUMENTATION, DEMOGRAPHICS & COPY OF INSURANCE CARD

PHONE: 972-810-0990 | FAX: 972-810-0994