Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name: | DOB:

Allergies: | Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Renal Transplant Recipient — ICD 10 Code: Z94.0

☐ Other: _____ — ICD 10 Code: _____

☐ Other: _____ — ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider

☐ Patient demographics AND insurance information

☐ Labs and Tests supporting primary diagnosis

*Patient may be required to submit a pregnancy test prior to treatment

☐ Clinical/Progress notes supporting primary diagnosis (must be within 1 year)

☐ TB Test Results

☐ EBV Serostatus

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt (in kg): BMI:

Initial Dosing	☐ Nulojix 10mg/kg IV Day 1, Day 5 end of week 2 and week 4 after transplantation, end of weeks 8 and 12 after transplantation
Maintenance Dosing	☐ Nulojix 5mg/kg at end of week 16 after transplantation, then every 4 weeks

PREMEDICATIONS

☐ Acetaminophen ☐ 500mg PO ☐ 650mg PO ☐ 1000mg PO

☐ Loratadine (Claritin) 10mg PO

☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Methylprednisolone (Solu-Medrol) ☐ 40mg IV ☐ 125mg IV

☐ Hydrocortisone (Solu-Cortef) ☐ 100mg IV

☐ Other: _____

Duration ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses**

ADDITIONAL ORDERS / INFORMATION

☐ Distribution Number: _____

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ CRP ☐ at each dose ☐ every _____

☐ Micro Albumin Protein/Creatinine Ratio ☐ at each dose ☐ every _____

☐ Other:

PRESCRIBER INFORMATION

Prescriber name :

Office Phone: | Office Fax: | Office Email:

Prescriber Signature: | Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Suite 204 Mattoon, IL 61938
Ph. 217-258-4150 Fax 217-348-2579

☐ EFFINGHAM
901 Medical Park Dr. Suite 201 Effingham, IL 62401
Ph. 217-342-7500 Fax 217-342-7499

INFUSION ORDERS - NULOJIX (BELATACEPT)

Clinics Scan to: Physician Orders