Cumberland Vital Care

Fax Referral To: (931) 456-4857

Direct Phone: (931) 456-0680

NULOJIX ORDER FORM

Date: _____ ICD-10 Code: _____

Patient Name: _____ Allergies: _____

Date of Birth: _____ Weight: _____lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ Provider Address: _____

Provider Phone: _____

MEDICATION ORDER

Nulojix	☐ Initation: **Day 1** (day of transplantation and prior to implantation) and **Day 5** (approximately 96 hours after Day 1 dose), **End of week 2 and week 4** after transplantation, **End of week 8 and week 12** after transplantation: **Infuse Nulojix 10mg/kg IV over 30 minutes** ☐ Maintenance: End of week 16 after transplantation and every 4 weeks (plus or minus three days) thereafter: **Infuse Nulojix 5mg/kg IV over 30 minutes**	Refills x one year from date of signature unless indicated below. ☐ _____ Refills	***Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:*** ✓ Seropositive EBV Result. ✓ Negative TB Quantiferon Gold, or TB Skin Test within the last 12 months. ✓ Total infusion dose should be based on actual body weight at time of transplantation Dose should not be modified during the course of therapy unless there is a change in body weight of greater than 10%. ✓ Weight at time of transplant: _____ lbs

PRE-MEDICATIONS

Oral

- ☐ Acetaminophen: _____325mg _____500mg _____650mg
- ☐ Loratadine: 10mg
- ☐ Cetirizine: 10mg
- ☐ Diphenhydramine: _____25mg _____50mg
- ☐ Famotidine: _____20mg _____40mg
- ☐ Ibuprofen: _____200mg _____400mg _____600mg
- ☐ Ondansetron: _____4mg _____8mg
- ☐ Other: _____

IV

- ☐ Dexamethasone: _____4mg _____8mg
- ☐ Diphenhydramine: _____25mg _____50mg
- ☐ Famotidine: _____20mg _____40mg
- ☐ Methylprednisolone: 125mg
- ☐ Hydrocortisone: 100mg
- ☐ Ondansetron: _____4mg _____8mg
- ☐ Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Ofice Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

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

Dispense as Written:

_____ _____
Prescriber Name Date

Substitution Allowed:

_____ _____
Prescriber Name Date

V 9.27.23