TwelveStone Health Partners

Fax Referral To: (800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

NULOJIX ORDER FORM

Date: _____

Patient Name: _____

Date of Birth: _____

ICD-10 Code: _____

Allergies: _____

Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

Provider Information

Ordering Provider: _____

Provider NPI: _____

Provider Phone: _____

Provider Fax: _____

Provider Address: _____

MEDICATION ORDER

☐ Nulojix

☐ Initiation: **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 transplatation:
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 5gm/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, TB Skin Test or Chest X-Ray 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: _____ mg IV over _____ mins
- ☐ 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

OTHER REQUIRED DOCUMENTATION

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

- History & Physical, Last Office 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