



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION

Primary ICD-10 Code: _____ Secondary ICD-10 Code: _____ Tertiary ICD-10 Code: _____

Transplant Date: _____ - _____ - _____ Epstein-Barr Virus (EBV): Seropositive Seronegative or unknown (contra-indicated)

Will Nulojix be used with basiliximab induction, mycophenolate mofetil, and corticosteroids? Yes No

Is patient not able to tolerate cyclosporine or tacrolimus due to allergy or intolerance? Yes No

NULOJIX® ORDERS

Prescription type: New start Restart Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose/Frequency	Refills
<input type="checkbox"/> Nulojix® (belatacept) initial dosing <input type="checkbox"/> Nulojix® (belatacept) maintenance dosing	<input type="checkbox"/> 10 mg/kg to nearest 12.5 mg increment IV over 30 minutes on day 1 before transplantation, on day 5 approximately 96 hours after the first dose, and at the end of weeks 2, 4, 8, and 12. <input type="checkbox"/> 5 mg/kg to nearest 12.5 mg-increment IV over 30 minutes at the end of week 16 and every 4 weeks +/- 3 days thereafter <input type="checkbox"/> Other: _____	Refills: _____

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X _____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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