# NULOJIX®

**Please Fax Completed Form To: 888-898-9113**

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

| 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: ☐ M ☐ F Weight: ______(lbs) Ht: ______ | Phone: ______ Fax: ______ |
| Allergies: ______ | Office Contact: ______ Phone: ______ |

## INSURANCE INFORMATION – AND – 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 |
|---|---|---|
| ☐ Nulojix® (belatacept) initial dosing<br>☐ Nulojix® (belatacept) maintenance dosing | ☐ 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.<br>☐ 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<br>☐ 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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