

## NULOJIX REFERRAL FORM (PAGE 1 OF 2)

TODAY'S DATE \_\_\_\_\_

CURRENT PATIENT  NEW PATIENT

**PLEASE FAX REFERRAL FORM TO:**

- BiologicTx - NJ**  
TEL: 877-567-8087 FAX: 877-567-8089
- BiologicTx - CA**  
TEL: 800-404-1963 FAX: 800-404-4595
- BiologicTx - IL**  
TEL: 888-892-7607 FAX: 877-567-8089
- Decillion Healthcare**  
TEL: 800-622-9321 FAX: 866-548-8849

- Elwyn Specialty Care**  
TEL: 855-359-9679 FAX: 610-545-6030
- Factor Support Network**  
TEL: 877-376-4968 FAX: 805-482-6324
- Matrix Health**  
TEL: 877-337-3002 FAX: 888-385-2805
- Med Center Specialty Pharmacy**  
TEL: 855-633-5633 FAX: 304-344-0655
- MedEx BioCare**  
TEL: 800-962-6339 FAX: 901-382-3091

Patient Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_  Male  Female  
 Street Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Daytime Tel \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ BSA \_\_\_\_\_  
 Ship to Patient at  Home  Work OR Patient will pick up at  Physician Office Local Pharmacy Phone \_\_\_\_\_  
 Allergies \_\_\_\_\_ Comorbidities \_\_\_\_\_  
 Current Medications (if necessary, please fax a complete list) \_\_\_\_\_

PRACTICE NAME	ADDRESS	PHONE	PRIMARY CONTACT

PRESCRIBER INFORMATION (PLEASE INCLUDE PHYSICIAN NAME AND NPI#)			
<input type="checkbox"/>	_____ # _____	<input type="checkbox"/>	_____ # _____
<input type="checkbox"/>	_____ # _____	<input type="checkbox"/>	_____ # _____
<input type="checkbox"/>	_____ # _____	<input type="checkbox"/>	_____ # _____

Insured's Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
 Eligible for Medicare  Yes  No If yes, Medicare# \_\_\_\_\_ Prescription Card  Yes  No If Yes, Carrier \_\_\_\_\_  
 Tel \_\_\_\_\_ Fax \_\_\_\_\_ Policy/Group# \_\_\_\_\_  
 Bin# \_\_\_\_\_ Pcn# \_\_\_\_\_ RXID# \_\_\_\_\_ RX Group# \_\_\_\_\_

ICD-10:  T86.10 Unspecified Complication of Kidney Transplant  T86.11 Kidney Transplant Rejection  
 T86.12 Kidney Transplant Failure  T86.13 Kidney Transplant Infection  
 T86.19 Other Complication of Kidney Transplant  
 Transplant Date: \_\_\_\_\_  
 Medical History:  Diabetes  Hypertension  Other: \_\_\_\_\_ Blood Type: \_\_\_\_\_  
 PRA Level \_\_\_\_\_ (attach copy of results)  Epstein-Barr Virus (EBV)  Seropositive  Seronegative or unknown (contra-indicated)

**PRESCRIPTION PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS**

PHYSICIAN ORDERS - NULOJIX THERAPY		DOSE	DIRECTIONS	QTY	REFILLS
Infuse Nulojix (Belatacept) IV in 100ml NS or D5W IV over 30 minutes or as tolerated					
<b>MUST BE DIVISIBLE BY 12.5</b>					
<input type="checkbox"/>	10 mg/kg _____ mg		Day 5, day 14, day 28		0
<input type="checkbox"/>	10 mg/kg _____ mg		End of week 2 and week 4 after transplantation		0
<input type="checkbox"/>	5 mg/kg _____ mg		End of week 16 after transplantation and every 4 weeks (+/- 3 days)		
Preferred site of service: <input type="checkbox"/> Home <input type="checkbox"/> AIC _____ <input type="checkbox"/> Hospital Clinic _____					

PHYSICIAN ORDERS - OTHER THERAPY							
MEDICATION	STRENGTH	DOSE	ROUTE	DIRECTIONS	QTY	REFILLS	DAW (Initial)
<input type="checkbox"/> Simulect® (Basiliximab)	20 mg/vial	20 mg	IV	X1 dose on post-transplant day 4		0	
<input type="checkbox"/> CellCept® (Mycophenolate Mofetil)		1000 mg	PO	Twice a day post-op day 0 to day 30		0	
<input type="checkbox"/> CellCept® (Mycophenolate Mofetil)		750 mg	PO	Twice a day beginning post-op day 31			
<input type="checkbox"/> Myfortic® (Mycophenolic acid delay release)		720 mg	PO	Twice a day post-op day 0 to day 30		0	
<input type="checkbox"/> Myfortic® (Mycophenolic acid delay release)		540 mg	PO	Twice a day post-op day 31			
<input type="checkbox"/> Prednisone		15 mg	PO	Daily for 1st six weeks post-transplant			
<input type="checkbox"/> Prednisone		10 mg	PO	Daily			

**COMPLETE PAGE 2 WITH CLINICAL INFORMATION**

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Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

### PRESCRIPTION

### PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

#### ANAPHYLAXIS/FLUSH/SUPPLY ORDERS *(Supplies will be provided as per therapy requirements)*

Anaphylaxis Kit:  Adult

*This Anaphylaxis Kit includes:* Diphenhydramine injection 25mg/ml – 2ml vials #2

Diphenhydramine 25mg PO capsules #2

Epinephrine 1mg/ml – 1 ml ampule to be administered for allergic reaction as directed by MD

Flush Orders: PRN Catheter Maintenance

Saline 0.9% Flush 5-10 ml

#### NURSING ORDERS

Provide skilled nursing care to complete therapy.

Baseline Vital Signs: BP, HR, Temp prior to infusion, every 15 minutes until completion.

Provide education regarding medication, disease state, adverse drug reactions, and administration. Observe for response to therapy.

Peripheral IV Access: Insert, maintain, and de-access according to company policy and procedure.

Reconstitute vial(s) and dilute using aseptic technique according to manufacturer's instructions.

Use only the silicone-free disposable syringes provided.

Do not shake vials.

#### PLEASE INCLUDE THE FOLLOWING

PRA Level (attach copy of results)

Complete Patient History, including any previous transplants and dates, lab results

#### COMMENTS

By signing this form and utilizing our services, you are authorizing BioMatrix Specialty Pharmacy, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

**Prescriber's Signature** (signature required. NO STAMPS) \_\_\_\_\_ *Dispense as written* **Date** \_\_\_\_\_

**Prescriber's Signature** (signature required. NO STAMPS) \_\_\_\_\_ *Product Substitution Permitted* **Date** \_\_\_\_\_

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