BIOMATRIX SpRx

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#)

☐ _____ #_____ ☐ _____ #_____ ☐ _____ #_____
☐ _____ #_____ ☐ _____ #_____ ☐ _____ #_____
☐ _____ #_____ ☐ _____ #_____ ☐ _____ #_____

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

Infuse Nulojix (Belatacept) IV in 100ml NS or D5W IV over 30 minutes or as tolerated

DOSE MUST BE DIVISIBLE BY 12.5	DIRECTIONS	QTY	REFILLS
☐ 10 mg/kg _____ mg	Day 5 (approximately 96 hours after 1st dose day of transplantation)		0
☐ 10 mg/kg _____ mg	End of week 2, week 4, week 8, and week 12 after transplantation		0
☐ 5 mg/kg _____ mg	End of week 16 after transplantation and every 4 weeks (+/- 3 days)		

Preferred site of service: ☐ Home ☐ AIC_____ ☐ Hospital Clinic_____

PHYSICIAN ORDERS - OTHER THERAPY

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

COMPLETE PAGE 2 WITH CLINICAL INFORMATION

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NULOJIX
REFERRAL FORM *(PAGE 2 OF 2)*

Patient Name _____ DOB _____

PRESCRIPTION — PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

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

Anaplylaxis Kit: ☐ Adult

This Anaplylaxis 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 where allowed by law or contract.

Prescriber's Signature *Dispense as written (signature required. NO STAMPS)* **OR** *Product Substitution Permitted (signature required. NO STAMPS)* **Date**_____

Prescriber's Email_____