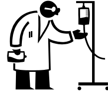

Infusion Associates
3230 Eagle Park NE, Suite 101
Grand Rapids, MI 49525
Phone: 616-954-0600 Fax: 616-954-1675

Nulojix IV Infusion ORDERS
(Belatacept)

******Please fax a copy of patient's Demographics, Insurance information, Current Lab Results, H&P, and Current Medications*

Date: _____/_____/_____

Patient Name: ____ **DOB**: _____/_____/_____

Allergies: _______________________________ **Patient Weight:** _________lbs / kg **Height:**_________

Diagnosis:_________________________ **Dx Codes**: ***ICD-10*** : ____________________, _________________

PT#______________________

LABS to be drawn:
- ☐ CBC
- ☐ Liver Function Tests:
- ☐ Other:______________

Lab Frequency:
- ☐ Prior to Nulojix infusions
- ☐ Other:_________________

Pre- Medications: (usually not indicated):____

Start Date of Infusion: _____/_____/_____ **Nulojix Infusion #** ___________

Nulojix IV Dosage:

☐ **5mg/kg** ☐ **10mg/kg** ☐ **Other: _____________**

DOSING SCHEDULE:

EVERY 4wks______ or 2wks_______

Rx Expiration Date: _____/_____/_____

Printed Provider's Name: ____

Provider Signature: ____

Office Phone Number: _______________________**Office Fax Number:** __________________________________