BioPlus® Infusion

Fax your completed order to 877-734-1157

Patient Name: _____ DOB: ___/___/_____

Date of Last Infusion: ___/___/_____ Height _____ Weight _____

Infusion Location: (state and site) _____

Nulojix® (belatacept) Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):

_____ Post-renal transplant AND EBV positive
(ICD-10)

_____ Other: _____
(ICD-10)

- Hold infusion and notify provider for:
  - Signs or symptoms of illness or active infection or Recent live vaccinations
  - New or worsening neurological, cognitive or behavioral signs/symptoms
- Monitor vital signs before and after infusion
- Notify provider of change in weight greater than 10% from baseline ("current weight" above)
- If infusion-related reaction occurs, stop infusion and initiate Hypersensitivity Reaction Management Protocol as clinically indicated

Labs:

☐ CBC with diff	☐ CMP	☐ Other

Frequency: _____

Administer Nulojix _____ mg/kg x (current weight) _____ kg = _____ mg
(will be rounded to nearest 12.5 mg)

-In 100 mL 0.9% sodium chloride over a period of 30 minutes using a sterile, non-pyrogenic, low protein binding filter (pore size 0.2 to 1.2 microns)

-For doses exceeding 1000 mg, dilute in 250 ml 0.9% sodium chloride.

Frequency: ☐ Every 4 weeks (+/- 3 days) ☐ Every _____ weeks

Additional Orders:

_____

_____

_____

Provider Name (print) _____ Date: _____

Provider Signature: _____ Time: _____