Allergy, Asthma & Immunology Center, P.C.
Infusion Services
www.aaicenter.net
Iftikhar Hussain, MD

Fax Referrals To: (855) 891-2191
Have a Question? (855) 478-1528

NULOJIX® (BELATACEPT) ORDER FORM

(- Required Fields)*

___ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

_____ **New Referral** _____ **Order Renewal** _____ **Medication/Order Change**
_____ **Benefits Verification Only** _____ **Discontinuation Order**

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: M F
ADDRESS:		PHONE:	
WEIGHT: LBS KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

NULOJIX ORDER*:

*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10*: ______________________________

____ **Initial Dosing:** 10mg/kg IV Day 1, Day 5, end of week 2 and week 4 after transplantation, end of weeks 8 and 12 after transplantation

OR

_____ **Maintenance Dosing:** 5mg/kg end of week 16 after transplantation and every 4 weeks thereafter

Physician Signature* ______________________________ **Date*(Order is Valid for One Year)** ____________________
Infusion will be administered per policy and protocols

REQUIRED DIAGNOSIS:

_____ Kidney Transplant Status

_____ Other______________________

***STAT REASON:**
(STAT request will be assessed per MPP policy and protocol)

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics

_____ Insurance Card/Information

_____ Clinical/Progress Notes supporting DX

_____ Current Medication List and H&P

Last Infusion/Injection Date: ____________________

STANDING LAB ORDERS: _____ CMP _____ CBC

____ Labs to be drawn by Infusion Center Frequency ______________________________

NOTES/ADDITIONAL COMMENTS:

Locations:

-------Oklahoma-------

___ Tulsa

REVISION DATE- 05/2020