PARAGON HEALTHCARE

NULOJIX (BELATACEPT) INFUSION ORDERS

P: 877.365.5566 | **F:** 855.889.2946

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

MEDICAL INFORMATION

Diagnosis: ☐ Kidney Transplant ☐ Other: _____

ICD-10 Code: _____ Allergies: _____

Patient weight at time of transplantation: _____ lbs. (required)

Patient weight (current): _____ lbs.

THERAPY ORDER

Dosing for Initial Phase and Initial Maintenance (10mg/kg until week 12, then 5mg/kg starting at week 16)

☐ Nulojix _____ mg IV on Day 1 (day of transplantation, prior to transplantation) and Day 5, at the end of week 2, week 4, week 8, and week 12 after transplantation.Then, _____mg IV at the end of week 16 after transplantation and every 4 weeks (plus or minus 3 days) thereafter x 1 year

*Patient has received _____ doses thus far, next dose due on _____

Dosing for Maintenance Phase (5mg/kg)

☐ Nulojix _____ mg IV every 4 weeks x 1 year

☐ **Other:** _____

** Prescribed doses must be evenly divisible by 12.5mg**

** The total infusion dose of Nulojix should be based on the actual body weight of the patient at the time of transplantation, and should not be modified during the course of the therapy, unless there is a change in the body weight of greater than 10%. If the patient has had a >10% weight change, please notify the physician for dose change recommendations**

Lab Orders: _____ **Frequency:** ☐ Every infusion ☐ Other: _____

☐ Yearly TB QFT screening (optional)

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

Other orders: _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Paragon selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

PARAGON HEALTHCARE

COMPREHENSIVE SUPPORT FOR NULOJIX (BELATACEPT) THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes (H&P) to support primary diagnosis
  - ☐ Will Nulojix be used in combination with basiliximab induction, mycophenolate mofetil, and corticosteroids? ☐ Yes ☐ No
- ☐ Labs attached
- ☐ Other medical necessity: _____

REQUIRED INFORMATION

- ☐ **TB screening test completed within 12 months - attach results**
  ☐ **Positive** ☐ **Negative**
- ☐ **EBV serostatus - attach results**
- ☐ **Nulojix Distribution Program notification (855) 511-6180 - Patient ID#** _____

*If TB results are positive - please provide documentation of treatment or medical clearance and a negative CXR

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance