



Conveniently Located in East Syracuse, Onondaga Hill & Auburn

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**Nulojix (belatacept) Non-Oncology Treatment Order Set**

1. Patient Name: \_\_\_\_\_

2. DOB: \_\_\_\_\_ Height (inches): \_\_\_\_\_ Weight (lbs): \_\_\_\_\_

**3. Diagnosis:**

Z94.0 Kidney transplant status

Other ICD-10 Code: \_\_\_\_\_ Diagnosis description: \_\_\_\_\_

**4. Pre-medications:**

Acetaminophen:

1000mg PO  500mg PO

Diphenhydramine:

25mg PO  50mg PO  25mg IV  50mg IV

Hydrocortisone: 100mg IVP

Other Pre-medication: \_\_\_\_\_

No Pre-medications indicated

**5. Drug Order:**

**Nulojix (belatacept)** *Ok to substitute with generic/biosimilar*

5mg/kg IV every 4 weeks

Other: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

New to Therapy

Continuing therapy: Last Dose Received \_\_\_\_\_ Next Dose Due \_\_\_\_\_

Transplant Date: \_\_\_\_\_

*HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral*

**6. Infusion Lab Requirements:**

CBC & CMP within 2 weeks prior to each infusion

Other: \_\_\_\_\_

*HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.*

*The prescribing physician is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.*

**7. Required Baseline Lab/Testing have been completed:**

CBC/CMP, date: \_\_\_\_\_  TB (within past 12 months), date: \_\_\_\_\_  EBV serology, date: \_\_\_\_\_

**8. Patient Assistance & REMS Program Enrollment**

Patient is enrolled into the Nulojix Distribution Program (NDP) via Bristol-Myers Squibb (BMS)

Patient specific ID #: \_\_\_\_\_ (attach copy of enrollment paperwork)

7. Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(This drug administration order form is valid for 12 months)*