



GREATER BOSTON INFUSION CENTER

17/19 Kendrick St, Wrentham, MA 02093

P 774-581-0032 | F 774-581-0033

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Nulojix - Referral Checklist

Referral packet checklist

Complete this page and attach the supporting items below.

PATIENT & REFERRING PROVIDER

PATIENT NAME

DOB

DATE

REFERRING PROVIDER

NPI

DIRECT CONTACT / EXT.

OFFICE / PRACTICE

PHONE

FAX

EMAIL

URGENT CLINICAL CONTACT

REQUIRED REFERRAL PACKET

- ☐ Patient demographics and contact information
- ☐ Primary and secondary insurance information; front/back card copies
- ☐ Supporting clinical notes / office visits documenting Nulojix treatment plan
- ☐ Current medication list and allergies
- ☐ Relevant laboratory results / imaging and baseline safety information
- ☐ Completed Nulojix prescribing order (following page)

MEDICATION-SPECIFIC CLINICAL DOCUMENTATION

- Note should include any therapies tried/failed, and must include discussion about Nulojix
- Medication list and allergies
- Required: EBV seropositive result, baseline CBC w diff
- Recommended: frequent monitoring of CBC w diff

GBIC INTERNAL USE

REFERRAL RECEIVED

BENEFITS VERIFIED

PA STATUS / THROUGH

SCHEDULED



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Prescribing Order - Nulojix (belatacept)

☐ New Start

☐ Maintenance

DATE OF LAST DOSE / INFUSION

ORDER DETAILS

DATE OF ORDER

PATIENT NAME

DOB

M/F

DIAGNOSIS / ICD-10

☐ NKDA

PATIENT WEIGHT

ALLERGIES

PREMEDICATIONS

☐ Acetaminophen 1000mg PO

☐ Diphenhydramine 25mg IV

☐ Loratadine 10mg or Cetirizine 10mg PO

☐ Solu-medrol 125mg IV

☐ Diphenhydramine 25mg PO

☐ Other

LAB ORDERS



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Prescribing Order - Nulojix (belatacept) (continued)

NULOJIX MEDICATION ORDER

☐ Maintenance Dosing: 5mg/kg every 4 weeks

☐ Other

Refills

ADMINISTRATION & MONITORING

- ✓ Reconstitute Nulojix with sterile water and dilute in 100ml Normal Saline. Administer via 0.2 micron filter
- ✓ intravenously over 30 min
- ✓ Do not administer if patient has active signs or symptoms of infection or PTLD.
- ✓ In case of infusion reaction, STOP infusion and follow GBIC infusion reaction protocol. Notify physician.
- ✓ Signature Date

PROVIDER AUTHORIZATION

ORDERING PROVIDER NAME

NPI

DATE

SIGNATURE

OFFICE PHONE / EXT.

Handwritten or compliant electronic signature