NEW ENGLAND
Cancer Specialists
Infusion Center
Kennebunk – Scarborough – Topsham - Portsmouth
Phone: 207-303-3225 Fax:207-692-2473

Nulojix (Belatacept) Order Form – J0485

Patient Name:_____ **DOB:**_____

Diagnosis: _____ Diagnosis Code:_____

Height: _____(cm) Actual Weight: ____(kg) Allergies: _____

Please list any premeds needed here_____

*****Required tests prior to administration: TB screening, EBV serostatus**

Nulojix (Belatacept): **Please check all that apply**

Initial Phase:

☐ **10mg/kg at end of week 2, 4, 8, 12 after transplant**

Maintenance Dose:

☐ **5mg/kg every 4 weeks starting at end of week 16 after transplant**

Orders valid through ___/___/____

***In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.**

Provider Name: _____

Provider Signature: _____ Date: _____

Phone: _____ Fax: _____ Pager: _____