TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

NULOJIX®

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____
NPI #: _____ Tax ID: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Office Contact: _____ Phone: _____

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____
Plan #: _____
Group #: _____
RX Card (PBM): _____
BIN: _____ PCN: _____

Secondary Insurance (If Applicable): _____
Plan #: _____
Group #: _____
RX Card (PBM): _____
BIN: _____ PCN: _____

CLINICAL INFORMATION

Primary ICD-10 Code:_____ Secondary ICD-10 Code:_____ Tertiary ICD-10 Code:_____

Transplant Date: _____-_____-_____ Epstein-Barr Virus (EBV): ☐ Seropositive ☐ Seronegative or unknown (contra-indicated)

Will Nulojix be used with basiliximab induction, mycophenolate mofetil, and corticosteroids? ☐ Yes ☐ No

Is patient not able to tolerate cyclosporine or tacrolimus due to allergy or intolerance? ☐ Yes ☐ No

NULOJIX® ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose/Frequency	Refills
☐ Nulojix® (belatacept) initial dosing ☐ Nulojix® (belatacept) maintenance dosing	☐ 10 mg/kg to nearest 12.5 mg increment IV over 30 minutes on day 1 before transplantation, on day 5 approximately 96 hours after the first dose, and at the end of weeks 2, 4, 8, and 12. ☐ 5 mg/kg to nearest 12.5 mg-increment IV over 30 minutes at the end of week 16 and every 4 weeks +/- 3 days thereafter ☐ Other: _____	Refills: _____

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X_____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.