Atrium Health Infusion Centers
Phone: 704-468-3400 **Fax:** 704-468-3401

Nulojix Infusion Order (Revised 6/24/21)

Instructions to Provider: All orders with ☒ will be placed unless otherwise noted. Please fax completed order, along with referral form.

Required Lab Results: EBV-VCA Antibody IgG (If outside of Atrium, please fax with order, required prior to scheduling)

Infusion Therapy:

☐ Nulojix (belatacept) _____IV over 30mins **ICD-10 Code: _____**

Frequency: every _____ weeks

Pre-Meds: (*Administer 30 Minutes prior to Nulojix*)

☐ Acetaminophen _____ mg PO x 1

☐ Benadryl _____ mg PO

☐ Benadryl _____ mg IV

☐ Loratadine 10mg PO x 1

☐ SoluMedrol _____ mg IV x1

☐ Zofran _____ mg IV x 1

Additional Orders:

_____

_____

PRN Meds:

☐Zofran 4mg IV every 3 hours PRN nausea/vomiting

☐Ibuprofen 800mg PO every 8 hours PRN pain

Special Instructions:

- Follow Atrium Health Infusion Center protocol for hypersensitivity PRN.

Infusion Monitoring:

- Obtain vital signs pre- and post-infusion. Obtain vital signs PRN during infusion.
- Monitor for signs of reaction for 30 mins after completion PRN if previous signs of reaction observed

Physician Name: _____

Physician Signature: _____

Date: _____ (Order valid for 1 year)

Patient Name:

DOB:

MRN: