



Nulojix (Belatacept) Referral Form

Transplant | Patient Referral Form

FAX completed form to Axiva 800-216-1369

Transplant@axiva.com | www.axiva.com

Referral Status: New Referral Updated Order Order Renewal NEXT DUE DATE:

Infusion Setting: Home Infusion

PATIENT INFORMATION

Date: Patient Name: Last 4 SSN: DOB:

Address: City: ST: Zip:

Primary Phone: Work Phone / Cell:

Gender: M F Weight lbs/kg: Height: Allergies:

Primary Insurance: Secondary Insurance:

Primary Member / Insurance ID: Secondary Member / Insurance ID:

Diagnosis Code: Z79.62 — Chronic Immunosuppression Z79.621 — CNI Toxicity

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Referral Coordinator Cell Number:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

- Establish and/or maintain access device as needed
- Administer by ordered route (IV over 30 min)
- Obtain vital signs prior to and post infusion
- If reaction occurs follow reaction management protocol

LABORATORY ORDERS

- CBC at each dose every
- CMP at each dose every
- CRP at each dose every

NULOJIX THERAPY ADMINISTRATION

- Initial Dosing:** 10 mg/kg IV — Day 1, Day 5, end of Week 2, Week 4, Week 8, and Week 12 after transplantation
- Maintenance Dosing:** 5 mg/kg IV every 4 weeks (+/- 3 days) beginning at end of Week 16

Transplant Date:

Current Dosing Phase:

- D1 D5 W2 W4 W8 W12 Maint

Dose based on actual body weight at transplant. Modified if weight changes >10%. Rounded to nearest 12.5 mg.

Additional Orders / Notes:

REQUIRED DOCUMENTATION

- Patient Demographics
- Insurance Card / Information
- Progress Notes Supporting DX
- Current Medication List and H&P
- EBV Seropositive — Belatacept is CONTRAINDICATED in EBV-seronegative patients

****Order is valid for one year unless otherwise noted****

By signing I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. Axiva Health Solutions, Inc., has my permission to contact the patient's health plan to obtain authorizations necessary to enable it to receive payment for services.

Provider Name (Print)	Provider Signature	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>

Email Referrals To: Transplant@axiva.com | Fax: 800-216-1369 | www.axiva.com

3796 Howell Branch Rd, Winter Park, FL 32792

Revision Date 2/2026

Have a Question?

Transplant@axiva.com

www.axiva.com

