Columbus Community Hospital
Columbus, Nebraska
DOCTORS ORDERS

PLEASE NOTE: Condition of Wound, Removal of Stitches, Consultation, Change in Diagnosis, Complications, Condition on Discharge, Instructions of Patient.

PLEASE SIGN AND DATE EACH ENTRY

PLEASE INDICATE / ALLERGIES

NONE	CODEINE	PENICILLIN	SULFA	ASPIRIN	OTHER	HEIGHT
REACTION						WEIGHT

Authorization is granted to supply medications by non-proprietary name unless checked here ☐

PHYSICIANS ORDERS
(including Medications)

Belatacept (NULOJIX) **(8/2024)** **Page 1 of 3**

Diagnosis Code: _____

Treatment Start Date: _____ Patient to follow up with provider on date: _____

This plan will expire after 365 days at which time a new order will need to be placed

GUIDELINES FOR ORDERING

1. Send **FACE SHEET** and **H&P or most recent chart note.**
2. A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order. If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order.
3. Patient's Epstein - Barr virus (EBV) status must be confirmed as seropositive prior to initiation of therapy.
4. Please indicate patient's Epstein-Barr Virus (EBV) positivity and date:
   Results positive (date): _____
5. Patients should have regular monitoring for TB and infection. Prophylaxis against bacterial, viral, fungal, and protozoal organisms should be considered. In particular, prophylaxis against CMV and PJP should be considered for first 3 months post-transplant.
6. Belatacept (Nulojix) dosing is based on actual body weight at time of transplantation; do not modify weight-based dosing during course of therapy unless change in body weight is greater than 10%. Please record patient's actual body weight at time of transplantation: _____kg or current dosing weight (if different): _____kg.
7. Belatacept (Nulojix) is subject to a limited distribution program which requires patient registration for procurement. Referring providers must enroll patient and provide program ID for patients to be scheduled.
8. Nulojix Distribution Program Enrollment ID: _____

PRE-SCREENING: (Results must be available prior to initiation of therapy):

- ☐ Epstein-Barr virus (EBV) test results (must be included with orders)
- ☐ Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders
- ☐ Chest X-Ray result scanned with orders if TB test result is indeterminate.

LABS:

- ☐ CBC with differential, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ CMP Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ Magnesium (plasma), Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ Phosphorous (plasma), Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ Other Labs:_____

NURSING ORDERS:

1. TREATMENT PARAMETER – Hold treatment and contact provider if TB test result is positive or if screening has not been performed.
2. TREATMENT PARAMETER – Hold treatment and contact provider Epstein-Barr Virus (EBV) test result is negative, or if screening has not been performed.

(cont.)

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PHYSICIANS ORDERS
(including Medications)

Belatacept (NULOJIX)

NURSING ORDERS (CONTINUED)

3. VITAL SIGNS – Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion and at the end of infusion
4. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes

MEDICATIONS:

- **belatacept (NULOJIX)** in sodium chloride 0.9%, 100 mL, intravenous, ONCE over 30 minutes
  Pharmacist will round dose to nearest increment of 10mg
  - **Initial Dose:**
    ☐ 10 mg/kg
    Interval: (*must check one*)
    ☐ Once
    ☐ Four doses at 2, 4, 8 and 12 weeks
    (Dates: Week 2_____, Week 4_____ , Week 8_____ , Week 12_____)
  - **Maintenance Doses:**
    ☐ 5 mg/kg
    Interval:
    ☐ Every_____ weeks for doses
    (Beginning at week 16 = every 4 weeks, at least 28 days apart)

HYPERSENSITIVITY:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop **STOP THE INFUSION**.
2. Obtain vital signs and continue to monitor vitals every 5 minutes.
3. Notify ordering provider.
4. Refer to **Adult Hypersensitivity (HSR) & Allergic Reaction Management** algorithm for assessment guidelines and interventions.
5. Continue to assess as grade of severity may progress.
6. Administer emergency medications as directed on the physician's orders.

HYPERSENSITIVITY MEDICATIONS:

- **Acetaminophen**, **975 mg**, PO, x 1 dose, AS NEEDED for hypersensitivity or infusion reaction.
- **DiphenhydrAMINE inj, 50 mg**, IV, AS NEEDED for hypersensitivity or infusion reaction. May repeat x 1 AS NEEDED per reaction management algorithm.
- **Hydrocortisone Sodium Succinate, 100 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Famotidine, 20 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Oxygen, 2 Liters/min** per nasal cannula for hypersensitivity or infusion reaction.
- **0.9% Normal Saline, 1000 mL**, IV, 150mL/hr, AS NEEDED for hypersensitivity or infusion reaction.
- **EPINEPHrine HCl (1mg/1mL), 0.3 mg**, IM injection, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.

(cont.)

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Belatacept (NULOJIX) **Page 3 of 3**

My NPI number is _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____**Fax:** _____