



Nulojix Order Form

Select patient referral location: Blue Ash Worthington Crestview Hills Springfield West Cincinnati
Fax completed form to 888-977-0914. For new referrals, please include recent labs and last two office visit notes.

Toll Free Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> Lbs <input type="checkbox"/> Kg
Patient Status: <input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy <input type="checkbox"/> Next due date (if applicable):	

2. PHYSICIAN INFORMATION

Physician's name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:	State:	Zip:
Office contact:	Email:	
Office phone:	Office fax:	

3. DIAGNOSIS INFORMATION (and year of diagnosis)

Kidney Transplant ICD 10 (_____) Other (specify): _____

4. INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION (requires new order every 12 months)

NULOJIX <input type="checkbox"/> Initial <input type="checkbox"/> Maintenance	PRE-MEDICATIONS <input type="checkbox"/> N/A
Initial Phase	<input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg PO
<input type="checkbox"/> Day 1 (day of transplantation, prior to implantation) and Day 5 (approximately 96 hours after Day 1 dose) administer 10 mg/ kg IV	<input type="checkbox"/> Fexofenadine (Allegra) 180mg PO (or other non-sedating anti-histamine)
<input type="checkbox"/> Week 2 and Week 4 after transplantation administer 10 mg/kg IV	<input type="checkbox"/> Diphenhydramine (Benadryl) <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> PO <input type="checkbox"/> IV (requires driver)
<input type="checkbox"/> Week 8 and Week 12 after transplantation administer 10 mg/kg IV	<input type="checkbox"/> Methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg <input type="checkbox"/> 80mg <input type="checkbox"/> 125mg IV
	<input type="checkbox"/> Prednisone _____ mg PO
Maintenance Phase	<input type="checkbox"/> Other: _____
<input type="checkbox"/> End of Week 16 after transplantation administer 5 mg/kg IV	POST-MEDICATIONS <input type="checkbox"/> N/A
<input type="checkbox"/> Every 4 weeks (+/- 3 days) thereafter administer 5 mg/kg IV	<input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg PO
<input type="checkbox"/> _____	<input type="checkbox"/> Prednisone _____ mg PO
	<input type="checkbox"/> Other: _____

- Vital signs per HI Protocol
 Anaphylaxis & Hydration Management per HI Protocol

6. LABS

<input type="checkbox"/> CBC w/Diff	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> CRP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> CMP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> ESR	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Hepatic Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Renal Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Quantiferon TB Gold, annually, last completed (date): _____		
<input type="checkbox"/> Other (specify): _____		

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE