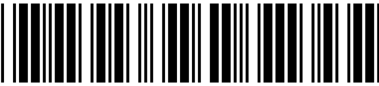
Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071 

ADULT AMBULATORY INFUSION ORDER

Belatacept (NULOJIX)

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: ____________kg **Height:** ____________cm

Allergies: ____

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. Patient's Epstein-Barr virus (EBV) status must be confirmed as seropositive prior to initiation of therapy, and results must be included with orders.
3. Tuberculosis screening (Tuberculin skin test or QuantiFERON Gold blood test) must result negative within the past year.
4. 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.
5. Belatacept 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 >10%.

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

- ☑ Epstein-Barr virus (EBV) test results (must be included with orders)
- ☐ QuantiFERON Gold, serum, Routine, ONCE

OR

- ☐ QuantiFERON Gold test results included with orders
- ☐ Tuberculin skin test results included with orders

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*
- ☐ Urine dipstick W/O Micro, Routine, ONCE, every ________ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Labs already drawn within ________ days – Labs scanned with orders

MEDICATIONS:

belatacept (NULOJIX) in NaCl 0.9% 100 mL, intravenous, ONCE over 30 minutes
Pharmacist will round dose to nearest increment of 12.5 mg and will modify during order verification

Initial Dose:
- ☐ 10 mg/kg = ___________ mg

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 = ______ mg

Interval:
- ☐ Every __________ weeks for _________ doses
  (Beginning at week 16 = every 4 weeks, at least 28 days apart)

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

HYPERSENSITIVITY MEDICATIONS:
1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-PAT-133-GUD). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ ________________ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license 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:**____________

OLC Central Intake Nurse:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient's preferred clinic location:

☐ **Beaverton**
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

☐ **NW Portland**
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

☐ **Gresham**
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

☐ **Tualatin**
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders