Oregon Health & Science University Hospital and Clinics Provider's Orders PO9031 ADULT AMBULATORY INFUSION ORDER **Belatacept (NULOJIX) Infusion** Page 1 of 3	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. 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. 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. Per manufacturer labeling, do not modify weight-based dosing during course of therapy unless change in body weight is greater than 10%. Dosing weight is set on treatment day 1 to patient's most current weight. Provider MUST contact pharmacy if a different starting dosing weight is preferred (i.e weight at time of transplant). Refer to Antineoplastic and Biologic Medication Management Policy (HC-MMM-117-POL) for details.
   Please record patient's actual body weight at time of transplantation: _____kg or current dosing-weight (if different): _____kg.
6. Pharmacist will round dose to nearest increment of 12.5 mg and will modify during order.
7. Please indicate patient's Epstein-Barr Virus (EBV) positivity and date:
   Results positive (date): _____

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*
- ☐ Complete metabolic panel, 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

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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.
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:

1. PROVIDER TO PHARMACIST COMMUNICATION - Pharmacist to update all belatacept to order-specific dosing on treatment day 1 based on current weight. For subsequent doses, if patient weight change is greater than 10%, contact provider per Antineoplastic and Biologic Medication Management Policy (HC-MMM-117-POL).

belatacept (NULOJIX) in sodium chloride 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 _____)
☐ Other: _____

Maintenance Doses:
☐ 5 mg/kg = _____ mg

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

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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 (OHSU HC-PAT-133-GUD, HMC C-132). 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 x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.5 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion 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**: _____

☑ **Please indicate the patient's preferred clinic location below**

☐	**HILLSBORO MEDICAL CENTER** 364 SE 8th Ave, Medical Plaza Suite 108B, Hillsboro, OR 97123	Phone (503) 681-4124 Fax (503) 681-4120
☐	**ADVENTIST HEALTH – PORTLAND** Infusion Services, 10123 SE Market St, Portland, OR 97216	Phone (503) 261-6631 Fax (503) 261-6756
☐	**ADVENTIST HEALTH – COLUMBIA GORGE** **Celilo Cancer Center, 1800 E 19th St, The Dalles, OR 97058**	Phone **(541) 296-7585** Fax **(541) 296-7610**