KAISER PERMANENTE®

Name: _____

Kaiser Permanente Member I.D. # _____

Date of Birth _____

Belatacept (Nulojix) – Maintenance
Infusion Therapy Plan Orders

Instructions to Provider

Review orders and note any changes. All orders with ☑ will be placed unless otherwise noted. Please fax completed order form to the infusion center where the patient will be receiving treatment (see fax numbers at the end of this protocol). Lab orders are not included on this form – place orders via usual method. Lab monitoring is the responsibility of the ordering physician.

Please complete all of the following:

☐ **Pre-Service Authorization** has been obtained by Kaiser Permanente **Fax:** 1-888-282-2685 **Voice**: 1-800-289-1363

☐ **Nulojix Distribution Program enrollment verification and Patient ID number:** _____

Order Date: _____ **Weight:** _____kg (at time of transplant)	**Diagnosis:** ICD-10 code *(REQUIRED):* Z94.O or _____ ICD-10 description Kidney Transplant Status or _____

General Plan Communication

- Maintenance Schedule: End of Week 16 post kidney transplant and every 4 weeks (plus or minus 3 days) thereafter
- Special instructions/notes: _____

Provider Information

- FDA REMS Program for belatacept
  - Provider and patient should be made aware of and monitor for the increased risk of post-transplant lymphoproliferative disorder (PTLD) predominately in the CNS and progressive multifocal leukoencephalopathy (PML).
  - Patient Medication Guide must be given to each patient at every infusion (see link below)
  - http://packageinserts.bms.com/medguide/medguide_nulojix.pdf
    - ☐ Ensure patient is Epstein-Barr virus (EBV) seropositive prior to initiation of therapy.
- Ensure baseline PPD or quantiFERON Gold blood test completed and read as negative within the past year.
- Regular monitoring for TB and infection. Prophylaxis against opportunistic infection as per kidney transplant standard protocol.
- Patient is Age 18 or older. Dosing guidelines for adults:

  Belatacept maintenance dose 5 mg/kg (dose rounded to the nearest 12.5 mg increment)*

  *If actual body weight at time of infusion has changed > 10% from actual body weight at time of transplantation, pharmacist will notify provider to confirm dose change.

☑ **belatacept (NULOJIX) in 0.9% sodium chloride 100 mL IV infusion**

Maintenance *Dose:* ☐ **5 mg/kg = _____ mg – round dose to nearest 12.5 mg increment. Use actual body weight.**

Route: Intravenous

Frequency: **Every 4 weeks for _____ doses 28 days apart (MUST be within 25 to 31 days of last infusion)**

Infuse over: 30 minutes

If infusion-related reaction:

1) STOP infusion immediately; 2) Increase primary infusion to wide open rate; 3) Administer PRN medications per hypersensitivity protocol; 4) Notify MD

Note any changes to above regimen: _____

Provider Signature: _____ **Date:** _____

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

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IV Line Care

- ☑ Administer with an infusion set and a sterile, non-pyrogenic, low-protein-binding filter (pore size of 0.2-1.2 µm).
- ☑ 0.9% sodium chloride infusion 250 mL
  Rate: 30 mL/hr *Route:* Intravenous *Frequency:* Run continuously to keep vein open
  Start peripheral IV if no central line

Infusion Reaction Meds

- ☑ Acetaminophen (TYLENOL) 325 mg tab. Take 2 tablets PO every 4 hours PRN for fever (greater than 100.4 F), myalgias, arthralgias or headache.
- ☑ Alteplase (CATHFLO ACTIVASE) Inj 2 mg INTRACATHETER PRN x 2 doses. Instill 2 mg to affected port(s) of central venous catheter if sluggish or occluded. Allow to dwell for 30 minutes, if unable to aspirate blood allow to dwell for an additional 90 minutes. May repeat one time if unsuccessful.
- ☑ diphenhydrAMINE (BENADRYL) 50 mg injection. Give IV push over 2 minutes one time, if needed for hives, rash, itching, flushing, and/or swelling in a suspected hypersensitivity reaction. Notify provider if patient experiences a hypersensitivity reaction.
- ☑ Famotidine (PEPCID) (PF) Inj 20 mg. Give IV push over 2 minutes for hives, rash, itching, flushing, and/or swelling in a suspected hypersensitivity reaction. Give immediately after diphenhydrAMINE. Notify provider if patient experiences a hypersensitivity reaction.
- ☑ methylPREDNISolone Sod Succ (PF) Inj 125 mg (SOLU-Medrol PF). Give 125 mg IV push one time PRN for shortness of breath, bronchospasm, or other symptoms of a suspected hypersensitivity reaction not otherwise specified. Notify provider if patient experiences a hypersensitivity reaction.
- ☑ Sodium Chloride 0.9% IV bolus 1,000 mL. Give IV over 1 hour one time PRN for hypotension due to presumed anaphylaxis. Notify provider if patient experiences a hypersensitivity reaction.
- ☑ EPINEPHrine (Epi-Pen) 0.3 mg/0.3 mL IM Auto-injector. Give IM one time PRN for severe cardiovascular or respiratory symptoms (e.g., dyspnea, wheeze/bronchospasm, stridor, hypoxemia) of a suspected hypersensitivity reaction. Provider must be present upon giving medication.

Lab Review for Nursing

When labs are available in Epic:

- Ensure CBC with manual diff, CMP, PO4, Mag have been drawn within the last 4 weeks.
- If labs have not been drawn within 4 weeks, draw required labs in the infusion center then proceed with infusion.
- Draw quantiFERON-TB Gold blood test prior to infusion if greater than 10 months since last TB status has been verified.
- If patient is more than 8 weeks overdue for labs, hold infusion and notify provider.

Nursing Orders

- Verify PPD or quantiFERON-TB Gold for latent TB results are negative for TB within the last year.
- Pre-Infusion checklist must be completed and scanned into patient's chart with each infusion.
- If patient answers positively during symptoms check, page ordering provider, call Nephrology clinic at 206-326-3587 or Nephrologist on-call.
- REMS alert – Medication Guide must be given to patient before EVERY infusion.
- Discontinue IV line when therapy complete and patient stabilized.
- Monitor and record pre- and post- infusion vital signs.

References

- NULOJIX® Full Prescribing Information.

Kaiser Permanente Infusion Locations

Please refer to the link below for the current list:
https://wa-provider.kaiserpermanente.org/patient-services/ambulatory-infusion

Provider Signature: _____ **Date:** _____

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