BLINCYTO® Order Form

Fax Completed Form To: **Phone:**

PATIENT INFORMATION		
Patient Name:	Date of Birth:	Referral Date:
Address:	City/State/Zip:	
Home Phone:	Cell Phone:	Work Phone:
Secondary Contact:	Height: Weight:	☐ Male ☐ Female
Patient Diagnosis & ICD-10:		
Allergies:		

PROVIDER INFORMATION		
Physician Name:	Lic.#:	DEA #:
Practice Name:		NPI#:
Address:	City/State/Zip:	
Office Contact:	Phone:	Fax:
Supervisory Physician (if applicable):		

PLEASE ATTACH

☐ Patient demographics & front/back copy of all insurance cards (prescription & medical)
☐ Recent office visit notes, history & physical, lab & pertinent procedure results
☐ Current medication list & list of prior medications tried and failed (with dates)
☐ Line access documentation/verification if applicable

☐ Vaccine status (any vaccination) and documentation of any recent vaccinations
☐ TB lab results within last 12 months
☐ HBV lab results within last 12 months (Infliximabs only)
☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines

NURSING & LAB ORDERS

Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.

Lab Orders: **Lab Date & Frequency:**

PRESCRIPTION ORDERS

Anaphylaxis Kit: ☐ Epinephrine 0.3mg IM as needed   ☐ NS Hydration 500 ml IV infusion over 30 minutes as needed

(Check all that apply)   ☐ Diphenhydramine _____ mg IV infusion as needed   ☐ Other

Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary

PRODUCT	PRESCRIPTION INFORMATION
☐ Blinatumomab (BLINCYTO®)	**Maintenance Orders (Consolidation cycles):** Dispense up to 9 cycles as ordered. Current cycle number: _____ Date current cycle initiated: _____ ☐ Infuse 28 mcg/day IV infusion continuously via ambulatory pump (patient weight ≥ 45 kg) x 28 days, followed by ____-day treatment-free interval. ☐ Infuse 15 mcg/m2/day IV infusion continuously via ambulatory pump (patient weight < 45 kg) x 28 days, followed by ____-day treatment-free interval. ☐ Infuse _____ mcg/day IV infusion continuously via ambulatory pump. Medicare Orders: E0781 Ambulatory Infusion (1 per month), A4222 IV Admin Kit (1 per bag/cassette), A4221 IV supplies (1 per week) **Ancillary Medication Orders:** Patients Weighing ≥ 45 kg (Select one of the following): ☐ Dexamethasone 20 mg IV one hour before 1st dose of each new cycle (relapsed/refractory) or when restarting an infusion after an interruption of 4 or more hours in the first cycle. ☐ Prednisone 100mg IV infusion one hour before 1st dose or each new cycle (MRD pos.) ☐ Other Premedication _____ Patients Weighing < 45 kg: Dexamethasone _____ (5 mg/m2 - max 20 mg) IV infusion one hour before 1st dose or each new cycle and when restarting an infusion after an interruption of 4 or more hours (for relapsed or refractory). **IV Flush Orders [Do not flush in between blinatumomab (Blincyto®) bag changes.]** ☐ PICC and Central Tunneled/Non-Tunneled: NS 5 mL pre-lab draw and 10 mL post-lab draw. For maintenance, heparin ☐ (10 unit/mL) 5 mL **or** ☐ (100 unit/mL) 3 mL every 24 hr to non-medication lumen. ☐ Implanted Port: When appropriate, NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use at completion of cycle. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed and not used for medication or weekly to monthly if not accessed.
☐ OTHER	

By signing this form and utilizing our services, you are authorizing Amerita, Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

_____ _____ _____
Prescriber's Signature   Print Name   Date
Dispense as Written

_____ _____ _____
Prescriber's Signature   Print Name   Date
Substitution Permitted

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