

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:	<input type="checkbox"/> Male <input type="checkbox"/> 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	
<input type="checkbox"/> Patient demographics & front/back copy of all insurance cards (prescription & medical) <input type="checkbox"/> Recent office visit notes, history & physical, lab & pertinent procedure results <input type="checkbox"/> Current medication list & list of prior medications tried and failed (with dates) <input type="checkbox"/> Line access documentation/verification if applicable	<input type="checkbox"/> Vaccine status (any vaccination) and documentation of any recent vaccinations <input type="checkbox"/> TB lab results within last 12 months <input type="checkbox"/> HBV lab results within last 12 months (Infliximabs only) <input type="checkbox"/> 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:	<input type="checkbox"/> Epinephrine 0.3mg IM as needed <input type="checkbox"/> NS Hydration 500 ml IV infusion over 30 minutes as needed (Check all that apply) <input type="checkbox"/> Diphenhydramine _____ mg IV infusion as needed <input type="checkbox"/> 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
<input type="checkbox"/> Blinatumomab (BLINCYTO®)	Maintenance Orders (Consolidation cycles): Dispense up to 9 cycles as ordered. Current cycle number: _____ Date current cycle initiated: _____ <input type="checkbox"/> Infuse 28 mcg/day IV infusion continuously via ambulatory pump (patient weight ≥ 45 kg) x 28 days, followed by ____-day treatment-free interval. <input type="checkbox"/> Infuse 15 mcg/m2/day IV infusion continuously via ambulatory pump (patient weight < 45 kg) x 28 days, followed by ____-day treatment-free interval. <input type="checkbox"/> 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): <input type="checkbox"/> 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. <input type="checkbox"/> Prednisone 100mg IV infusion one hour before 1st dose or each new cycle (MRD pos.) <input type="checkbox"/> 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).
<input type="checkbox"/> OTHER	IV Flush Orders [Do not flush in between blinatumomab (Blinicyto®) bag changes.] <input type="checkbox"/> PICC and Central Tunneled/Non-Tunneled: NS 5 mL pre-lab draw and 10 mL post-lab draw. For maintenance, heparin <input type="checkbox"/> (10 unit/mL) 5 mL or <input type="checkbox"/> (100 unit/mL) 3 mL every 24 hr to non-medication lumen. <input type="checkbox"/> 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.

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 _____
 Dispense as Written

Print Name _____
 Date _____

Prescriber's Signature _____
 Substitution Permitted

Print Name _____
 Date _____



ACHC ACCREDITED

