

# 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	
<b>Nurse Orders:</b> Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.	
<b>Lab Orders:</b>	<b>Lab Date &amp; Frequency:</b>

PRESCRIPTION ORDERS	
<b>Anaphylaxis Kit:</b>	<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
<b>Supply Orders:</b> 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®)	<b>Maintenance Orders (Consolidation cycles):</b> 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)
	<b>Ancillary Medication Orders:</b> 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	<b>IV Flush Orders [Do not flush in between blinatumomab (Blinicyto®) bag changes.]</b> <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 <b>or</b> <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

