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: (Check all that apply)
☐ Epinephrine 0.3mg IM as needed
☐ Diphenhydramine _____ mg IV infusion as needed
☐ NS Hydration 500 ml IV infusion over 30 minutes 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