# BLINCYTO® Order Form

**Fax completed form to:** _____

amerita specialty infusion services

EVENTUS INFUSION an amerita company

## 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):**<br>Dispense up to 9 cycles as ordered. Current cycle number: _____ Date current cycle initiated: _____<br>☐ Infuse 28 mcg/day IV infusion continuously via ambulatory pump (patient weight ≥ 45 kg) x 28 days, followed by ____-day treatment-free interval.<br>☐ Infuse 15 mcg/m2/day IV infusion continuously via ambulatory pump (patient weight < 45 kg) x 28 days, followed by ____-day treatment-free interval.<br>☐ Infuse _____mcg/day IV infusion continuously via ambulatory pump.<br>Medicare Orders: E0781 Ambulatory Infusion (1 per month), A4222 IV Admin Kit (1 per bag/cassette), A4221 IV supplies (1 per week)<br><br>**Ancillary Medication Orders:** Patients Weighing ≥ 45 kg (Select one of the following):<br>☐ 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.<br>☐ Prednisone 100mg IV infusion one hour before 1st dose or each new cycle (MRD pos.)<br>☐ Other Premedication _____<br>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).<br><br>**IV Flush Orders [Do not flush in between blinatumomab (Blincyto®) bag changes.]**<br>☐ 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.<br>☐ 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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ACHC ACCREDITED
ACCREDITED Compounding Pharmacy