


BLINATUMOMAB (BLINCYTO®) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

	Patient Name:	Date of Birth:			
	Address:				
	Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:
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Blinatumomab (Blinicyto®) Prescription

Blinatumomab (Blinicyto®)

Infuse 28 mcg/day IV continuously via ambulatory pump (patient weight \geq 45 kg).
 Infuse 15 mcg/m²/day (____) IV continuously via ambulatory pump (patient weight < 45 kg).

Current cycle number: ____ Date current cycle initiated: ____
Start day ____ through day ____ of 28-day cycle.

Medicare Orders: E0781 Ambulatory Infusion (1 per month), A4222 IV Admin Kit (1 per bag/cassette), A4221 IV supplies (1 per week)

Ancillary Orders

Medication Orders

Patients Weighing \geq 45 kg **(Select one of the following):**

- Dexamethasone 20 mg IV one hour before 1st dose of each new cycle (relapsed/refractory).
- Dexamethasone 16 mg IV one hour before 1st dose of each new cycle.
- Solu-Cortef® 400 mg IV one hour before 1st dose of each new cycle.
- Methylprednisolone 80 mg IV one hour before 1st dose of each new cycle.

Patients Weighing < 45 kg:

- Dexamethasone ____ (5 mg/m² – max 20 mg) IV one hour before 1st dose of each new cycle.

Other: _____

IV Flush Orders **[Do not flush in between blinatumomab (Blinicyto®) 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.

Lab Orders

- No labs ordered at this time.
- Other: _____

Blinatumomab (Blinicyto®) bag changes as required by infusion nurse until patient and/or caregiver trained to independent with bag changes. Infusion not to be interrupted > 4 hours.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature:	Date:
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Prescriber Information

Prescriber Name:	Phone:	Fax:
Address:	NPI:	
City, State:	Zip:	Office Contact:

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