BLINATUMOMAB (BLINCYTO®) PRESCRIBER ORDER FORM

Patient Name:	**Date of Birth:**
Address:	

Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Blinatumomab (Blincyto®) Prescription

Blinatumomab (Blincyto®)

☐ Infuse 28 mcg/day IV continuously via ambulatory pump (patient weight ≥ 45 kg).
☐ Infuse 15 mcg/m^2/day (____) IV continuously via ambulatory pump (patient weight < 45 kg).

Current cycle number: _____
Start day _____ through day _____ of 28-day cycle.

Date current cycle initiated: _____

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 ≥ 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.
☐ Methylprednisolone sodium succinate 80 mg IV one hour before 1st dose of each new cycle.

Patients Weighing < 45 kg:

☐ Dexamethasone _____ (5 mg/m^2 – max 20 mg) IV one hour before 1st dose of each new cycle.

☐ Other: _____

IV Flush Orders [Do not flush in between blinatumomab (Blincyto®) bag changes.]

☐ PICC and Central Tunneled/Non-Tunneled: 0.9% Sodium Chloride 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, 0.9% Sodium Chloride 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 (Blincyto®) 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:**

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:	**NPI:**	

City, State:	**Zip:**	**Office Contact:**

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

