

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 (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.
 Methylprednisolone sodium succinate 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: 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 (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:

Prescriber Information

Prescriber Name:

Phone:

Fax:

Address:

NPI:

City, State:

Zip:

Office Contact:

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

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