

Blinicyto Enrollment Form

TwelveStone Health Partners



Date: _____
 Patient Name: _____
 Date of Birth: _____

Fax Referral To:
(800) 223-4063

Direct Phone: (615) 278-3350
 Toll Free: (844) 893-0012

PREVIOUS ADMINISTRATION

If YES, please provide the following information:	If NO, please indicate desired location for first dose:
Last Infusion Date: _____ Next Infusion Date: _____	<input type="checkbox"/> Physician's Office <input type="checkbox"/> TwelveStone Infusion Center <input type="checkbox"/> TwelveStone Home Infusion <input type="checkbox"/> Other: _____ Desired Start Date: _____

DIAGNOSIS

Description	ICD-10 Code
<input type="checkbox"/> B-Cell Precursor Acute Lymphoblastic Leukemia	<input type="checkbox"/> C91.0

OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)

<input type="checkbox"/> This signed order form	<input type="checkbox"/> History and Physical
<input type="checkbox"/> Patient Demographics and Insurance Information	<input type="checkbox"/> Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)

CLINICAL INFORMATION (Please attach all clinical information, lab results and other medical history documents)

Patient Weight: _____ Kg/Lbs Height: _____ Inches/CM BSA: _____ Allergies: _____

Line Access: PIV PICC (SL DL TL) PORT (Huber size _____ Gauge _____ Length) Sub-Q

MEDICATION	DOSE	DIRECTIONS	LAB & ANCILLARY ORDERS
<input type="checkbox"/> Blinicyto	35mcg Vial: <input type="checkbox"/> > 45kg (fixed dose) <input type="checkbox"/> < 45kg (BSA based dose)	<input type="checkbox"/> <u>Induction</u> - Cycle 1-2 Cycle 1 - Infuse 28mcg (or 15mcg/m2) continuous IV infusion daily on days 10-28; followed by 14 days treatment free interval on days 29-42 Cycle 2 - Infuse 28mcg (or 15mcg/m2) continuous IV infusion daily on days 3-28; followed by 14 days treatment free interval on days 29-42 <input type="checkbox"/> <u>Consolidation</u> - Cycles 3-5 Infuse 28mcg (or 15mcg/m2) continuous IV infusion daily on days 1-28; followed by 14 days treatment free interval on days 29-42 <input type="checkbox"/> <u>Continued Therapy</u> - Cycles 6-9 Infuse 28mcg (or 15mcg/m2) continuous IV infusion daily on days 1-28; followed by 14 days treatment free interval on days 29-42	<input type="checkbox"/> CBC w/diff and CMP ___x weekly <input type="checkbox"/> Okay to proceed if ANC > ___ and PLT > ___ <input type="checkbox"/> Adjust dose by ___% if ANC > ___ and < ___ <input type="checkbox"/> Adjust dose by ___% if PLT > ___ and < ___ <input type="checkbox"/> Hold dose if ANC < ___ and/or PLT < ___ *Will Notify MD about any dose reduction **If Dosing Parameters are not selected then MD will be contacted for any lab or result not in the normal range

Premedication(s):	Ancillary Orders:
<input type="checkbox"/> Diphenhydramine 25-50 mg po – 25mg #2 per dose <input type="checkbox"/> Acetaminophen 325-650 mg po – 325mg #2 per dose <input type="checkbox"/> Methylprednisolone _____mg IV over _____mins <input type="checkbox"/> Other: _____	<input type="checkbox"/> NaCl 0.9% 5-10ml IV before and after infusion <input type="checkbox"/> Heparin 10 units/ml 3-5ml IV after infusion for peripheral access and PRN <input type="checkbox"/> Heparin 100 units/ml 3-5ml IV after infusion for central IV access and PRN <input type="checkbox"/> All infusion supplies necessary to administer the medication <input type="checkbox"/> Anaphylaxis Kit

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)
 By signing this form and utilizing our services, I am also authorizing TwelveStone to serve as my prior authorization agent with medical and pharmacy insurance providers

Physician' Phone# _____	Physician's NPI# _____	Physician's Fax# _____	Physician's Address _____
Dispense as Written _____	Printed Name _____	Substitution Allowed _____	Date _____

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