Blincyto Enrollment Form

Date: ______________________

Patient Name: ______________________

Date of Birth: ______________________

TwelveStone Health Partners

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: ______________________	☐ Physician's Office
Next Infusion Date: ______________________	☐ TwelveStone Infusion Center
	☐ TwelveStone Home Infusion
	☐ Other: ______________________
	Desired Start Date: ______________________

DIAGNOSIS

Description	*ICD-10 Code*
☐ B-Cell Precursor Acute Lymphoblastic Leukemia	☐ C91.0

OTHER REQUIRED DOCUMENTATION *(Please attach documents as needed)*

☐ This signed order form	☐ History and Physical
☐ Patient Demographics and Insurance Information	☐ 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
☐ Blincyto	35mcg Vial: ☐ > 45kg (fixed dose) ☐ < 45kg (BSA based dose)	☐ Induction - 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 ☐ Consolidation - 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 ☐ Continued Therapy - Cycles 6-9 Infuse 28mcg (or 15mcg/m2) continuous IV infusion daily on days 1-28; followed by 56 days treatment free interval on days 29-84	☐ CBC w/diff and CMP ___x weekly ☐ Okay to proceed if ANC > ____ and PLT > _____ ☐ Adjust dose by ____% if ANC > ____ and < ____ ☐ Adjust dose by ____% if PLT > ____ and < ____ ☐ 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):

- ☐ Diphenhydramine 25-50 mg po – 25mg #2 per dose
- ☐ Acetaminophen 325-650 mg po – 325mg #2 per dose
- ☐ Methylprednisolone______mg IV over_______mins
- ☐ Other: ____

Ancillary Orders:

- ☐ NaCl 0.9% 5-10ml IV before and after infusion
- ☐ Heparin 10 units/ml 3-5ml IV after infusion for peripheral access and PRN
- ☐ Heparin 100 units/ml 3-5ml IV after infusion for central IV access and PRN
- ☐ All infusion supplies necessary to administer the medication
- ☐ 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.

______________________	______________________	______________________	______________________
Dispense as Written	Printed Name	Substitution Allowed	Date

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