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:P
Last Infusion Date:_____ Next Infusion Date:_____	☐ **Physician's office** **TwelveStone Infusion Center** ☐ Canton ☐ Chattanooga ☐ Knoxville ☐ Mount Juliet ☐ Murfreesboro ☐ Other:_____ Date of last dose:_____

DIAGNOSIS

☐ B - cell Precursor Acute Lymphoblastic Leukemia ☐ MRD+ ☐ R/R	☐ 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)

MEDICATION	DIRECTIONS	REFILLS	BASELINE LABWORK REQ'D TO INITIATE (Check for TwelveStone to draw)
☐ Blincyto	35mcg Vial: ☐ > 45kg (fixed dose) < 45kg (BSA based dose) ☐ 5-mcg/m2/day ☐ 15-mcg/m2/day	☐ **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** **Day 1:_____ / Date to Transfer Home:_____** **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** **Day 1:_____ / Date to Transfer Home:_____** ☐ **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** **Day 1:_____ / Date to Transfer Home:_____** ☐ **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** **Day 1:_____ / Date to Transfer Home:_____**	☐ 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

Pre-medications:

☐ Diphenhydramine 25-50 mg po – 25mg #2 per dose

☐ Acetaminophen 325-650 mg po – 325mg #2 per dose

☐ Methylprednisolonemg 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)

Physician's Phone: _____ Physician's NPI#: _____ Physician's Fax# : _____ Physician's Address: _____

Dispense as Written: _____ Printed Name: _____ Substitution Allowed: _____ Date: _____