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

Is the patient currently on therapy? _____ Yes _____ No

If YES, please provide the following information:

Last Infusion Date: _____

Next Infusion Date: _____

If NO, please indicate desired location for delivery of first dose:

☐ Physician's Office

☐ Other: _____

DIAGNOSIS

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

☐ C91.0

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

☐ History and Physical ☐ This Signed Order Form ☐ 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
☐ 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< _____ ☐ Adjust dose by _____ % if ANC> _____ and< _____ ☐ Adjust dose by _____% if PLT> _____ and< _____ ☐ Hold dose if ANC< _____ and/or PLY< _____ *Will Notify MD about any dose reduction **If Dosing Parameters are not selected thenMD will be contacted for any lab or result not in the normal range*

PRE-MEDICATIONS

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

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

☐ Methylprednisolonemg IV over mins

☐ Other: _____

ANCILLARY ORDERS:

☐ NaCl 0.9% 5-0ml 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 access and PRN

☐ All infusion supplies necessary to administer the medication

☐ Anaphylaxis Kit

By signing below, I certify that the 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: _____

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