Blincyto Enrollment Form

Date: _____

Patient Name: _____

Date of Birth: _____

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: intake@12stonehealth.com

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)*

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

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

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