BLINCYTO Infusion Referral Form

Fax Referral To: 877-438-9380

ContinuumRx Specialty Infusion Services

Birmingham,AL	Huntsville, AL	Knoxville, TN	Nashville, TN	Chantilly, VA
F: 205-271-9971	F: 256-417-6408	F: 865-934-0249	F: 615-645-4791	F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ○ M ○ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: ○ Y ○ N

Emergency Contact: _____ Phone Number: _____

Primary Diagnosis: _____ B - cell Precursor Acute Lymphoblastic Leukemia

ICD-10 Code: _____ MRD+

_____ R/R

_____ Other: _____

Please attach the following: 1. Clinical MD Notes,/History 2. Most Recent Labs (Including Most Recent renal Function Tests and Any Other Tests Supporting Primary Diagnosis) 3. Copy of the patient's Insurance Card 4. Medications List

Physician Information

Prescribing Physician: _____ Practice Name: _____

Practice Phone: _____ Practice Fax: _____

Email: _____ Office Contact: _____

Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: BLINCYTO

35mcg Vial:

☐ ≥45kg (28mcg/day)

☐ <45kg (BSA _____ m2)

- ☐ 5-mcg/m2/day
- ☐ 15-mcg/m2/day (not to exceed, 28mcg/day)

☐ ***Initial Dose:***

☐ Cycle 1- Infuse 28mcg (or 15mcg/m2) continuous IV infusion daily; followed by 14 days treatment free interval on days 29-42 Day 1: _____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: ____ Transfer Home:_____

☐ ***Maintenance:***

☐ 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

☐ 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

Pre-Medication Orders:

☐ Per infusion clinic protocol: Acetaminophen 650 mg PO, Diphenhydramine 25 mg IV, and Methylprednisolone_____ IV (30 minutes prior to start of infusion)

☐ Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____

Physician's NPI# Physician's Address

_____ _____

Prescriber's Signature Date