INTRAMED Plus
infusion services

BLINCYTO®

HOME INFUSION ORDERS

1. ______________________ ______________ ______________
Patient Name **DOB** **Patient Phone/Cell #**

Patient demographic and insurance information to be faxed with Infusion Order Form

2. **Medical Information (Please select primary diagnosis and complete ICD10 Code):**

Primary Diagnosis: ______________________________ ICD-10 Code: __________

Allergies: ______________________________(or attach list)

3. **Clinical Information – Please fax with Infusion Order Form:**

- Clinical MD Notes & labs supporting primary diagnosis
- Medication List

Patient
Weight: ___________ lbs.
Height: ___________ in.

BLINCYTO® (blinatumomab) J Code: J9039

4. **Drug Order:**

❑ **For Patients 45 Kg or More:**
Administer Blincyto 28 mcg IV QD via continuous infusion pump on Day ____ through Day 28 of cycle

❑ **For Patients Less Than 45 Kg:**
Administer Blincyto 15 mcg/m2/day (________ mcg) IV QD via continuous infusion pump on Day ____ through Day 28 of cycle. Dose not to exceed 28 mcg/day.

For therapy coordination:
Date of Day 1 of current Cycle: ______________
Date of Day 28 of current Cycle: ______________

Intramed Plus to Provide: __________ Day Supply using either a 24-hour, 48-hour or 7-day bag based on Intramed's assessment of the patient and case.

Pre-Medications: ______________________________

Additional Prescriber Notes: ______________________________

____

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

5. **Physician Signature:** ____________________ / ____________________ Date: ____________
Dispense as written Substitution permitted

Printed Physician's Name: ______________________________ Contact Phone #: ______________

FAX ALL INFORMATION **CENTRAL FAX 803.794.0404** **ALTERNATE FAX 803.999.1887**	**LOCATIONS** **BERKELEY CHARLESTON COLUMBIA GREENVILLE** **CENTRAL INTAKE PHONE 803.794.0200**

JUNE 2023