INTRAMED Plus infusion services

BLINCYTO®

INFUSION & MEDICAL CENTER

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-Medication Orders: ______

Additional Prescriber Notes: ______

By signing this form and utilizing our 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 with Credentials: ______ Phone #: ______

FAX ALL INFORMATION	**CENTRAL INTAKE PHONE**
CENTRAL FAX 803.794.0404	**803.794.0200**