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