IV League Blincyto Order Form

Patient Information		
Patient Name:	Date of Birth:	
Patient Address:	Phone Number:	
Allergies:	Emergency Contact Name & Phone Number:	
IV Access:	Height (inches):	Weight (lbs):
Preferred Language: ☐English ☐Spanish ☐ Other, please specify: _____	Diagnosis:	ICD-10:
IV League Nursing Services Requested? ☐Yes ☐No, please specify home health: _____ Phone: _____		

Prescription Information	
Please specify:	☐Blincyto 28 mcg IV continuously over 24 hours daily for a total of 28 days ☐Blincyto _____ mcg IV continuously over 24 hours daily for a total of 28 days
Please confirm:	☐Patient will be admitted to start, planned admission date: _____ ☐Patient will start Blincyto at home, plan to start on date: _____

Pharmacy protocol includes the following standard orders for home Blincyto therapy

- If patient is starting Blincyto at home, premedicate with dexamethasone 20 mg IV push prior to first dose at home.
- Premedicate with dexamethasone 20 mg IV push as needed if Blincyto infusion is interrupted by more than 4 hours, prior to restarting the infusion.
- Adverse Reactions: Anaphylaxis kit to be used as needed for reaction per pharmacy protocol
- IV Maintenance: Line maintenance and flushing will be provided per pharmacy protocol
- Upon completion of Blincyto therapy, RN to aspirate 5-10 from line, discard, then flush with normal saline 20 ml & cap off line
- Skilled nursing visit to establish venous access, administer medication and assess general status & response to therapy.

Prescriber Information		
Prescriber Name:	Phone:	Fax:
Prescriber Address:		
NPI:	DEA:	License:
Prescriber Signature:		Date:

Please fax completed form to IV League Pharmacy at (310) 645-6464.

For any questions, please call our office at (310) 645-1500.