

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: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other, please specify: _____	Diagnosis:	ICD-10:
IV League Nursing Services Requested? <input type="checkbox"/> Yes <input type="checkbox"/> No, please specify home health: _____ Phone: _____		

Prescription Information	
Please specify:	<input type="checkbox"/> Blincyto 28 mcg IV continuously over 24 hours daily for a total of 28 days <input type="checkbox"/> Blincyto _____ mcg IV continuously over 24 hours daily for a total of 28 days
Please confirm:	<input type="checkbox"/> Patient will be admitted to start, planned admission date: _____ <input type="checkbox"/> Patient will start Blincyto at home, plan to start on date: _____
Pharmacy protocol includes the following standard orders for home Blincyto therapy	
<ul style="list-style-type: none"> 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 mL 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.

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