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Knoxville, TN F: 865-934-0249

Nashville, TN F: 615-645-4791

Chantilly, VA F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: Next Infusion Date:

Patient Information

Patient Name: DOB: Sex: M F Height: Weight: Phone Number: Email Address: Allergies: Is the patient Diabetic: Y N Emergency Contact: Phone Number:

Primary Diagnosis: B - cell Precursor Acute Lymphoblastic Leukemia ICD-10 Code: MRD+ R/R Other:

Please attach the following: 1. Clinical MD Notes,/History 2. Most Recent Labs (Including Most Recent renal Function Tests and Any Other Tests Supporting Primary Diagnosis) 3. Copy of the patient's Insurance Card 4. Medications List

Physician Information

Prescribing Physician: Practice Name: Practice Phone: Practice Fax: Email: Office Contact: Co-managing Physician: Phone/Email:

Medication Order

Medication: BLINCYTO

35mcg Vial: >=45kg (28mcg/day) <45kg (BSA m2) 5-mcg/m2/day 15-mcg/m2/day (not to exceed, 28mcg/day)

Initial Dose: Cycle 1- Infuse 28mcg (or 15mcg/m2) continuous IV infusion daily; followed by 14 days treatment free interval on days 29-42 Day 1: Transfer Home: Cycle 2- Infuse 28mcg (or 15mcg/m2) continuous IV infusion daily on days 3-28; followed by 14 days treatment free interval on days 29-42 Day 1: Transfer Home:

Maintenance: Cycles 3-5 - Infuse 28mcg (or 15mcg/m2) continuous IV infusion daily on days 1-28; followed by 14 days treatment free interval on days 29-42 Cycles 6-9 - Infuse 28mcg (or 15mcg/m2) continuous IV infusion daily on days 1-28; followed by 56 days treatment free interval on days 29-84

Pre-Medication Orders:

Per infusion clinic protocol: Acetaminophen 650 mg PO, Diphenhydramine 25 mg IV, and Methylprednisolone IV (30 minutes prior to start of infusion) Other:

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

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

Physician's NPI#

Physician's Address

Prescriber's Signature

Date