

# Briumvi

(Ublituximab-xiyy)

Treatment Location: Dublin, OH Lancaster, OH

**PROVIDERS: Please include the following to expedite the order:**

Patient Demographics, Insurance Information, All Clinical Documentation Supporting the Diagnosis, Including Any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing, Recent Labs Including Hep B Results and Serum Immunoglobulins.

## PATIENT INFORMATION

Referral Status:  New Referral  Updated Order  Order Renewal

Patient Name: \_\_\_\_\_ Patient Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

ICD-10 code (required):  G35.A  G35.C1 ICD Description: \_\_\_\_\_

Allergies: \_\_\_\_\_ Weight (lbs/kg): \_\_\_\_\_ Height: \_\_\_\_\_

Patient Status:  New to Therapy  Continuing Therapy Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

## PROVIDER INFORMATION

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## NURSING

- Center will use Hypersensitivity protocol established by Infuse One Ohio
- Hep B (HBsAg and anti-HBc) Test Results (list & attach clinicals):  
\_\_\_\_\_
- Serum Immunoglobulins (list results & attach clinicals)  
\_\_\_\_\_

## PRE-MEDICATION ORDERS

It is recommended to premedicate patients with an antihistamine and methylprednisolone (or equivalent corticosteroid) 30-60 minutes prior to each infusion.

- Diphenhydramine  25mg  50mg  PO  IV
- Acetaminophen  500mg  650mg PO
- Methylprednisolone  40mg  125mg IV
- Other: \_\_\_\_\_  
Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency: \_\_\_\_\_

## THERAPY ADMINISTRATION

- Briumvi Intravenous Infusion
  - Induction:  
First infusion: 150mg IV infusion over 4 hours  
Second infusion: 450mg IV infusion over 1 hour administered two weeks after first infusion
  - Maintenance:  
Subsequent infusions: 450mg IV infusion over 1 hour administered 24 weeks after first infusion and every 24 weeks thereafter
- Monitor patients for 1 hour after the completion of the first two infusions
- Refills:  Zero /  for 12 months /  \_\_\_\_\_  
(if not indicated order will expire one year from date signed)

*To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, Infuse One Ohio is authorized to administer a generic or biosimilar.*

Provider Name (Print) \_\_\_\_\_ Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

- Please check this box if you DO NOT authorize Infuse One Ohio to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.