

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 INFORMATIONReferral 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 ☐ 650mg ☐ 1000mg ☐ 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.