

TN  
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# Ublituximab-xiiy (Briumvi) Provider Order Form

Date: \_\_\_\_\_

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

**NURSING**

Hepatitis B status & date (list results here & attach clinicals)  
\_\_\_\_\_

Provide nursing care per ThrIVewell Procedures, including reaction management and post-procedure observation

**Based on the manufacturer PI, most payors require a quantitative serum immunoglobulin screening prior to Briumvi induction.**

I have attached results from a recent quantitative serum immunoglobulin test (list results here & attach clinicals):  
\_\_\_\_\_

Instruct ThrIVewell to draw quantitative serum immunoglobulin prior to first induction infusion (if required by payor).

**LABORATORY ORDERS**

CBC  at each dose  every \_\_\_\_\_

CMP  at each dose  every \_\_\_\_\_

CRP  at each dose  every \_\_\_\_\_

Other: \_\_\_\_\_  
Dose: \_\_\_\_\_ Route: \_\_\_\_\_  
Frequency: \_\_\_\_\_

**PRE-MEDICATION ORDERS**

*The following are manufacturer recommended premedication regimens:*

acetaminophen (Tylenol)  500mg /  650mg /  1000mg PO

methylprednisolone (Solu-Medrol)  40mg /  125mg IV

diphenhydramine (Benadryl)  25mg /  50mg  PO / IV

**ADDITIONAL PRE-MEDICATION ORDERS**

cetirizine (Zyrtec) 10mg PO

loratadine (Claritin) 10mg PO

Other: \_\_\_\_\_  
Dose: \_\_\_\_\_ Route: \_\_\_\_\_  
Frequency: \_\_\_\_\_

**THERAPY ADMINISTRATION**

**Ublituximab-xiiy (Briumvi) intravenous infusion**

**Induction:**  
**Dose: 150mg in 250ml 0.9% NS over four hours followed by 450mg in 250ml 0.9% NS over one hour two weeks later.**  
After induction, continue with the maintenance dosing and schedule below.

**Maintenance:**  
**Dose: 450mg in 250ml 0.9% NS over one hour 24 weeks after the first infusion and every 24 weeks thereafter.**

Flush with 0.9% NS at the completion of infusion

Patient required to stay for 60 minute observation post infusion of first two infusions. If no infusion reaction or hypersensitivity has been observed, patient is not required to stay for subsequent infusions.

Refills:  Zero /  for 12 months /  \_\_\_\_\_  
(if not indicated order will expire one year from date signed)

**SPECIAL INSTRUCTIONS**

## ORDERING PROVIDER

Signature X \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_