

Westerville  
575 Copeland Mill Road  
Suite# 2F  
Westerville, Ohio 43081



Lancaster  
2405 Columbus Street  
Suite# 210  
Lancaster, Ohio 43130

# Ublituximab-xiyy (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:

<b>NURSING</b> <input checked="" type="checkbox"/> Hepatitis B status & date (list results here & attach clinicals) <input checked="" type="checkbox"/> Provide nursing care per Thrivewell Procedures, including reaction management and post-procedure observation <b>Based on the manufacturer PI, most payors require a quantitative serum immunoglobulin screening prior to Briumvi induction.</b> <input type="checkbox"/> I have attached results from a recent quantitative serum immunoglobulin test (list results here & attach clinicals): <input type="checkbox"/> I instruct Thrivewell to draw quantitative serum immunoglobulin prior to first induction infusion (if required by payor). <b>LABORATORY ORDERS</b> <input type="checkbox"/> CBC <input type="checkbox"/> at each dose <input type="checkbox"/> every _____ <input type="checkbox"/> CMP <input type="checkbox"/> at each dose <input type="checkbox"/> every _____ <input type="checkbox"/> CRP <input type="checkbox"/> at each dose <input type="checkbox"/> every _____ <input type="checkbox"/> Other: _____ Dose: _____ Route: _____ Frequency: _____ <b>PRE-MEDICATION ORDERS</b> <i>The following are manufacturer recommended premedication regimens:</i> <input type="checkbox"/> acetaminophen (Tylenol) <input type="checkbox"/> 500mg / <input type="checkbox"/> 650mg / <input type="checkbox"/> 1000mg PO <input type="checkbox"/> methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg / <input type="checkbox"/> 125mg IV <input type="checkbox"/> diphenhydramine (Benadryl) <input type="checkbox"/> 25mg / <input type="checkbox"/> 50mg <input type="checkbox"/> PO / <input type="checkbox"/> IV <b>ADDITIONAL PRE-MEDICATION ORDERS</b> <input type="checkbox"/> cetirizine (Zyrtec) 10mg PO <input type="checkbox"/> loratadine (Claritin) 10mg PO <input type="checkbox"/> Other: _____ Dose: _____ Route: _____ Frequency: _____	<b>THERAPY ADMINISTRATION</b> <input checked="" type="checkbox"/> Ublituximab-xiyy (Briumvi) intravenous infusion <input type="checkbox"/> 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. <input type="checkbox"/> Maintenance: Dose: 450mg in 250ml 0.9% NS over one hour 24 weeks after the first infusion and every 24 weeks thereafter. <input checked="" type="checkbox"/> Flush with 0.9% NS at the completion of infusion <input checked="" type="checkbox"/> 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. <input type="checkbox"/> Refills: <input type="checkbox"/> Zero / <input type="checkbox"/> for 12 months / <input type="checkbox"/> _____ (if not indicated order will expire one year from date signed) <b>SPECIAL INSTRUCTIONS</b>
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## ORDERING PROVIDER

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

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