Borough Park
1428 36th Street
Suite 107
Brooklyn, NY 11218

Forest Hills
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

NYC
E 56th & Park Midtown
120 East 56 Street
Suite 300
New York, NY 10022

E 70th St Upper East Side
225 E 70th Street
Suite 1E
New York, NY 10021

Sheepshead Bay
2546 East 17th Street
Fl, 1
Brooklyn, NY 11235

Long Island City
36-36 33rd
Suite 311
Long Island City, NY 11106

FIDI
30 Broad Street
Suite 401
New York, NY 10004

Central Park West
115 Central Park West
Suite 15
New York, NY 10023

Bronx
226 West 238th Street
Bronx, NY 10463

Massapequa
97 Grand Avenue
Massapequa, NY 11758

Gramercy
7 Gramercy Park West
Lower Level
New York, NY, 10003

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

Tarrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523

Southampton
625 Hampton Road
Southampton, NY 11968

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

Port Jefferson
12 Medical Drive
Suite B
Port Jefferson Station, NY 11776

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

Rockville Centre
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

Staten Island
27 New Dorp Lane
Staten Island, NY 10306

Holbrook
233 Union Avenue
Suite 207
Holbrook, NY 11741

New Hyde Park
1991 Marcus Ave
Suite 110
Lake Success, NY, 11042

Woodbury
7600 Jericho Tpke,
Lower Level, Suite C500
Woodbury NY 11797

Ublituximab-xiiy (Briumvi)

Provider Order Form

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ 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.

☐ Ihave attached results from a recent quantitative serum immunoglobulin test (list results here & attach clinicals):
_____

☐ Iinstruct 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 _____