

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 ☐ 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 Brriumvi induction. ☐ I have attached results from a recent quantitative serum immunoglobulin test (list results here & attach clinicals): _____ ☐ I 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 <i>The following are manufacturer recommended premedication regimens:</i> ☐ 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-xiyy (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
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ORDERING PROVIDER

Signature X Date _____

Provider _____ Phone _____ Fax _____