Briumvi
(Ublituximab-xiiy)

Treatment Location: _____

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 INFORMATION

Referral 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 Infusion for Health and PI

☑ 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 ☐ 500mg ☐ 650mg PO

☐ Methylprednisolone ☐ 40mg ☐ 125mg IV

☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ Ig Panel ☐ at each dose ☐ every _____

☐ Urine Pregnancy ☐ at each dose ☐ every _____

☐ Other: _____ ☐ Frequency: _____

☐ Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

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, I4H is authorized to administer a generic or biosimilar.

Provider Name (Print) Provider Signature Date

☐ ***Please check this box if you DO NOT authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.***