Ublituximab-xiiy (Briumvi)

IVX HEALTH

Provider Order Form *rev. 1/11/23*

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA 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 Code:

NURSING

☑ Hepatitis B status & date (list results here & attach clinicals)
_____

☑ Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)

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):
_____

☐ I instruct IVX Health 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: _____

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

Provider Name (Print) **Provider Signature** **Date**

FAX NUMBERS				
	☐ CONNECTICUT: 860-955-1532	☐ HARRISBURG: 844-859-4235	☐ PALM BEACH: 561-768-9044	☐ TAMPA: 844-946-0849
	☐ CHICAGO: 312-253-7244	☐ INDIANAPOLIS: 844-983-2028	☐ PHILADELPHIA: 844-820-9641	☐ WEST TN/AR: 888-615-1445
☐ BAY AREA: 844-889-0275	☐ COLUMBUS: 844-627-2675	☐ JACKSONVILLE: 904-212-2338	☐ RALEIGH: 919-287-2551	☐ MIDDLE TN: 888-615-1445
☐ CHARLOTTE: 336-663-0143	☐ DAYTONA: 386-259-6096	☐ KANSAS CITY: 844-900-1292	☐ SARASOTA: 941-870-6550	☐ EAST TN: 615-425-7427
☐ CINCINNATI: 844-946-0868	☐ FT. LAUDERDALE: 754-946-2052	☐ ORLANDO: 844-946-0867	☐ SOUTHWEST FL: 813-283-9144	