Fax: 832-895-4040
Phone: 832-895-5000
E-mail: intake@adaptivinfusion.com

adaptIV infusion

Briumvi (Ublituximab-xiiy)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status *(check one):* ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____

NKDA ☐ Allergies: _____ Weight _____ *Please specify:* ☐ lbs ☐ kg Height: _____

Patient Status *(check one):* ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

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

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation
☐ Hepatitis B status & date (list results here & attach clinicals):

_____

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 AdaptIV Infusion to draw quantitative serum immunoglobulin prior to first induction infusion (if required by payor).

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 INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

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

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK