TwelveStone Health Partners

Fax Referral To:(800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

BRIUMVI ORDER FORM

Date: _____ ICD-10 Code: _____

Patient Name: _____ Allergies: _____

Date of Birth: _____ Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

Provider Information

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ Provider Address: _____

Provider Phone: _____

MEDICATION ORDER

☐ Briumvi

☐ First Infusion: Administer Briumvi 150mg IV over 4 hours x one dose. Infuse at 10mL/hour x 30 minutes; if tolerated, increase to 20mL/hr x 30 minutes; if tolerated, increase 35mL/hr x 1 hour; if tolerated, then increase 100mL/hr for the remaining two hours. Infusion duration: 4 hours.

☐ Second Infusion: Administer Briumvi 450 mg IV over one hour two weeks after first infusion. Infuse at 100mL/hr x 30 minutes; if tolerated, then increase 400mL/hr for the remaining 30 minutes. Infusion duration: 1 hour

☐ Maintenance Infusions: Administer Briumvi 450mg IV over one hour 24 weeks after the first infusion and every 24 weeks thereafter. Infuse at 100mL/hr x 30 minutes; if tolerated, then increase 400mL/hr for the remaining 30 minutes. Infusion duration: 1 hour.

✓ Pre-medications will be given as indicated below unless designated otherwise. Antihistamine dosage and route to be determined by on site provider if not specified.

✓ Pregnancy test prior to each infusion for females of reproductive potential.

✓ Patient will be observed for at least one hour after first two infusions. Post-infusion monitoring of subsequent infusions is at physician discretion unless infusion reaction and/or hypersensitivity has been observed in association with the current or any prior infusion.

Refills x one year from date of signature unless indicated below.

☐ _____Refills

Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:

✓ Hepatitis B Surface Antigen.
✓ Hebatitis B Core Antibody Total (Not Core IgM).
✓ Quantitative Serum Immunoglobulin Screening (Prior to initiation phase of treatment)

PRE-MEDICATIONS

Oral

✓ Acetaminophen: _____ 325mg _____ 500mg __X__ 650mg

☐ Loratadine: _____ 10mg

☐ Cetirizine: _____ 10mg

✓ Diphenhydramine: _____ 25mg _____ 50mg

☐ Famotidine: _____ 20mg _____ 40mg

☐ Ibuprofen: _____ 200mg _____ 400mg _____ 600mg

☐ Ondansetron: _____ 4mg _____ 8mg

☐ Other: _____

IV

☐ Dexamethasone: _____ 4mg _____ 8mg

✓ Diphenhydramine: _____ 25mg _____ 50mg

☐ Famotidine: _____ 20mg _____ 40mg

✓ Methylprednisolone: _____ 125mg

☐ Hydrocortisone: _____ 100mg

☐ Ondansetron: _____ 4mg _____ 8mg

☐ Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written:

_____ _____
Prescriber Name Date

Substitution Allowed:

_____ _____
Prescriber Name Date

V 11.22.23