

**TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: referral@12stonehealth.com

**BRIUMVI ORDER FORM**

Patient Name: _____	ICD-10 Code: _____	<b>Therapy Status</b>  <input type="checkbox"/> New Start  <input type="checkbox"/> Continuing Therapy: _____ Last Dose: _____
Date of Birth: _____	Allergies: _____	
Weight: _____ lbs OR _____ kg		

**Provider Information**

Ordering Provider: \_\_\_\_\_ Provider Fax: \_\_\_\_\_  
Provider NPI: \_\_\_\_\_ Provider Address: \_\_\_\_\_  
Provider Phone: \_\_\_\_\_

**MEDICATION ORDER**

<b>Briumvi</b>	<input type="checkbox"/> First Infusion: Administer Briumvi 150mg IV over 4 hours x one dose. Infuse at 10mL/hr 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. <input type="checkbox"/> 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 <input type="checkbox"/> 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. <input checked="" type="checkbox"/> Pre-medications will be given as indicated below unless otherwise specified. Antihistamine dosage and route to be determined by physician. <input checked="" type="checkbox"/> 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 for one year from date of signature unless indicated below.  _____ Refills	<b>Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</b>  <input checked="" type="checkbox"/> Baseline AST/ALT & Bilirubin <input checked="" type="checkbox"/> Hepatitis B Surface Antigen. <input checked="" type="checkbox"/> Hepatitis B Core Antibody Total (Not Core IgM). <input checked="" type="checkbox"/> Quantitative Serum Immunoglobulin Screening (Prior to initiation phase of treatment)
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**PRE-MEDICATIONS**

<b>Oral</b> <input checked="" type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: _____ 10mg <input type="checkbox"/> Cetirizine: _____ 10mg <input checked="" type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____	<b>IV</b> <input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg <input checked="" type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input checked="" type="checkbox"/> Methylprednisolone: _____ 125mg <input type="checkbox"/> Hydrocortisone: _____ 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____
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**LAB ORDERS** (please indicate any labs to be drawn and frequency)**OTHER REQUIRED DOCUMENTATION**

**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) <ul style="list-style-type: none"><li>• History &amp; Physical, Last Office Visit Note</li><li>• Patient Demographics and Insurance Information</li><li>• Medication List</li><li>• Recent Lab Work</li></ul>
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**By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)**

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

Prescriber Signature \_\_\_\_\_ Date \_\_\_\_\_