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: _____

Date of Birth: _____ Allergies: _____

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 otherwise specified. Antihistamine dosage and route to be determined by physician.

✓ 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

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

✓ Baseline AST/ALT & Bilirubin

✓ 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 ____ 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

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 615-278-3355)

- 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)*

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

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