Cumberland Vital Care
Fax Referral To:(931) 456-4857
Direct Phone: (931) 456-0680

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

✓ 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

To be given 30-60 minutes prior to infusion

~~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: __X__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 800-223-4063)

- History & Physical, Last Ofice 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