



Briumvi Infusion Orders

Patient Name: _____ DOB: _____ Male Female

Diagnosis (please provide ICD10 code) _____

New Start Therapy Continuation of Therapy Date of last dose (if applicable): _____

NKDA Allergies: _____

Ordering Provider: _____

Provider NPI: _____ Phone: _____ Fax: _____

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

PRE-MEDICATION

- Acetaminophen 1000mg PO
- Diphenhydramine 25mg PO
- Ceterizine 10mg PO
- Solu-Medrol 125mg IVP
- Solu-Cortef 100mg IVP
- Diphenhydramine 25mg IVP

REQUIRED DOCUMENTS

- Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (please attach)

*Patient will receive above premeds per Infuse One Medication Safety Protocol unless different premeds are noted below

Other PreMeds: _____

BRIUMVI ORDER

Loading dose: 150mg followed by **450mg** 2 weeks later

Maintenance dose: 450mg given 24 weeks after 1st dose and then every 24 weeks thereafter

Infuse One Standing Orders:

- Provide treatment under Infuse one's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

Provider Name

Provider Signature

Date