Fax: 561-516-6626 | Email: Info@infuseone.com | Phone 561-337-4055

Briumvi Infusion Orders

INFUSE ONE

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

- ☑ Acetaminophen1000mgPO
- ☐ Diphenhydramine25mgPO
- ☐ Ceterizine 10mg PO
- ☑ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☑ Diphenhydramine 25mg IVP

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

REQUIRED DOCUMENTS

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

☐ 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