

Ublituximab-xiiy (Briumvi)

Provider Order Form rev. 01/02/2024

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____ Patient Phone: _____

Patient Address: _____ Patient Email: _____

Allergies: _____ NKDA Weight (lbs/kg): _____ Height (in/cm): _____

Sex: M / F Date of Last Infusion: _____ Next Due Date: _____ Preferred Location: _____

DIAGNOSIS (Please provide ICD-10 code in space provided)

Multiple Sclerosis: _____

Other: _____ Description: _____

THERAPY ADMINISTRATION

- Induction Week 0: Administer Briumvi 150mg diluted in 250ml NS and infused over 4 hours (*infusion rates below*)
- Induction Week 2 & week 24: Administer Briumvi 450mg diluted in 250ml NS and infused over 1 hour (*infusion rates below*)
- Maintenance: Administer Briumvi 450mg every 6months (24weeks) diluted in 250ml NS and infused over 1 hour
- Monitor Patient for 60mins after the first 2 infusions

DOSING REFERENCE

Infusion	150mg dose (Duration at least 4 hours)	450mg dose (Duration at least 1 hour)
0	10 ml/hr x30mins	100ml/hr x 30mins
30 min	20 ml/hr x30mins	400ml/hr x 30mins
60 min	35ml/hr x60mins	
120 min	100 ml/hr x120mins	

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

- All pre-medication needs to be administered 30 minutes prior to infusion
- Tylenol 500mg / 650mg PO
- Loratadine 10mg PO
- Pepcid 20mg PO / IVP
- Benadryl 25mg / 50mg PO / IVP
- Solumedrol 40mg / 125mg IVP
- Other: _____

NURSING

- Hold infusion and notify provider for:
 - Signs/symptoms of infection
 - Recent live vaccines
 - POSITIVE pregnancy test
- Monitor vital signs with every rate change, then every 60 minutes and prior to discharge
- Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: _____ Preferred Contact Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

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

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, MRI results

Required Labs: Negative Hepatitis B, Quantitative Immunoglobulin lab results, Negative pregnancy test, JCV

Provider Name (*print*)

Provider Signature

Date