Ublituximab-xiiy(Briumvi)

Provider Order Form rev. 9/18/2025

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)*

☐ G35.A Relapsing-Remitting MS ☐ G35.B0 Primary Progressive MS, Unspecified ☐ G35.B1 Active Primary Progressive MS

☐ G35.B2 Non-Active Primary Progressive MS ☐ G35.C0 Secondary Progressive MS, Unspecified ☐ G35.D MS, Unspecified

☐ G35.C1 Active Secondary Progressive MS ☐ G35.C2 Non-Active Secondary Progressive MS ☐ Other:

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 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

☐ Tylenol ☐ 500mg / ☐ 650mg PO

☐ Loratadine 10mg PO

☐ Pepcid 20mg ☐ PO / ☐ IVP

☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP

☐ Solumedrol ☐ 40mg / ☐ 125mg IVP

☐ Other: _____

☑ All pre-medication needs to be administered 30 minutes prior to infusion

NURSING

☑ Hold infusion and notify provider for:

- Active HepB
- 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**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.