Briumvi Order Form
(ublituximab-xiiy)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code

☐ G35 Multiple Sclerosis

Other: _____

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

LAB RESULTS: **: Include quantitative serum immunoglobulin & Negative Hepatitis B within 3 years to initiate therapy.**

PRESCRIPTION

Pre-Medications

Required:

☐ Diphenhydramine: 25 mg PO, may repeat q 6 hours, PRN infusion reaction **OR**

☐ Diphenhydramine: 25 mg IVP, may repeat q 6 hours, PRN infusion reaction

Methylprednisolone: 125 mg SIVP

Optional:

☐ Acetaminophen: 500 mg PO, may repeat q 4-6 hours, PRN infusion reaction

☐ Other: _____

Briumvi (ublituximab-xiiy)

Loading Dose: NEW PATIENTS MUST HAVE BOTH LOADING DOSE AND MAINTENANCE DOSE

☐ **IV:** Infuse 150 mg in 250 mL of 0.9% Sodium Chloride at 10 mL/hr for 30 minutes, increase to 20 mL/hr for next 30 minutes, increase to 35 mL/hr for the next hour, then increase to 100 mL/hr for remaining 2 hours via pump using a 0.2-micron filter,

THEN

Infuse 450 mg in 250 mL of 0.9% Sodium Chloride at 100 mL/hr for 30 minutes and then increase to 400 mL/hr for remaining 30 minutes via pump using 0.2-micron filter 2 weeks after initial dose

Maintenance Dose: (FROM WEEK 0) *select maintenance dosing in addition to loading for on-going therapy*

☐ **IV:** Infuse 450 mg in 250 mL of 0.9% Sodium Chloride at 100 mL/hr for 30 minutes and then increase to 400 mL/hr for remaining 30 minutes via pump using a 0.2-micron filter every 24 weeks for one year

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

Post Treatment Observations: The patient is observed for 60 minutes following first two infusions and 15 minutes following subsequent infusions.

Comments:

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____