

An Outpatient Department of St. Mary's Hospital
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Ublituximab-xiiy (Briumvi®)

Along with this order form, please include the following: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. ArrIVE Infusion will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: ____/____/____

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

Patient Name: _____ Patient Address: _____ Patient Phone Number: _____ Date of Birth: ____/____/____ Weight: ____ kg Height: ____ cm Allergies: _____		Primary Insurance: _____ Member ID: _____ Secondary Insurance: _____ Member ID: _____			
Diagnosis ☐ Multiple Sclerosis (G35) ☐ Relapsing Forms of Multiple Sclerosis (G35.11) ☐ Secondary Progressive Multiple Sclerosis (G35.3) ☐ Other Diagnosis Code (ICD-10): _____ ☐ Other Indication: _____ Target start date: _____		Labs ☐ CBC with/diff ☐ Immunoglobulin IgM ☐ Immunoglobulin IgG ☐ HCG ☐ Other: _____			
Date of Negative Hepatitis Screen: _____					
Hold and notify provider: Patient has signs/symptoms of an active infection (WBC greater than ULN, ANC greater than ULN, etc) or positive pregnancy test.					
Ublituximab-xiiy (Briumvi®) in sodium chloride 0.9% 250 mL IVPB <table> <tr> <td> Dose: ☐ 150 mg ☐ 450 mg ☐ Other: _____ </td> <td> Frequency : ☐ Induction Dose 150 mg IV followed by 450 mg IV 2 weeks later ☐ Maintenance Dose: every 24 weeks ☐ Other: _____ </td> </tr> </table>				Dose: ☐ 150 mg ☐ 450 mg ☐ Other: _____	Frequency : ☐ Induction Dose 150 mg IV followed by 450 mg IV 2 weeks later ☐ Maintenance Dose: every 24 weeks ☐ Other: _____
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Pre-Medications and Pre-Protocol (ordered at physician discretion)	☐ Acetaminophen 650 mg PO once ☐ Loratadine 10 mg PO once ☐ Diphenhydramine once ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV ☐ Famotidine 20 mg IV once ☐ Hydrocortisone 100 mg IV once ☐ Methylprednisolone 125 mg IVP once ☐ Other: _____	Hydration ☐ LR ☐ Sodium Chloride 0.9% ☐ Other: _____ _____ mL at _____ mL/hr ☐ Before ☐ During ☐ Following			

Flushing Protocol <i>as needed for line care</i>	☐ Sodium Chloride 0.9% ☐ 5 mL ☐ 10 mL	Heparin 100 Units/mL ☐ 5 mL ☐ 10 mL
Hypersensitivity Panel Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy as necessary	• Sodium chloride 0.9% bolus 500 mL once as needed for hypotensive management (SBP <90mmHg) • Acetaminophen 650 mg once as needed for temperature GREATER than 38 C (100.4 F), headaches, generalized pain, back pain, abdominal cramping • Albuterol 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg, nebulize every 10 min PRN, hypoxemia, bronchospasm, wheezing, dyspnea, for 2 doses • Albuterol HFA inhaler 2 puffs q4hs as needed for hypoxemia, bronchospasm, wheezing, dyspnea • Epinephrine injection 0.3 mg IM every 15 minutes as needed for SBP less than 90mmHg, mild to moderate anaphylaxis for 3 doses • Famotidine injection 20 mg IV over 2 minutes once as needed for severe hypersensitivity/infusion reaction including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • Diphenhydramine injection 25 mg IV over 1 minute once as needed, moderate hypersensitivity/infusion reaction (grade 2) including temperature greater than 100.5, rigors, localized rash/hives, vomiting, nausea, pruritis, flushing, dizziness, back pain, abdominal cramping, uneasiness, agitation, feeling of impending doom • Diphenhydramine injection 50 mg IV over 1 minute once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • Hydrocortisone sodium succinate injection 100 mg IV once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure	
Provider Name: _____ Provider Signature: _____ Attending Physician Name: _____ Provider NPI: _____ Office Phone Number: _____ Office Fax Number: _____ <i>Note: This order is valid for 12 months from date of physician signature.</i>		