SPECIALTY INFUSION CENTER
An Access Infusion Care Company

# BRIUMVI (UBLITUXIMAB-XIIY) ORDERS

## PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____

Address: _____ Phone: _____ Allergies: _____

City, State, Zip: _____ Email: _____

## REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Is this the first dose? ☐ Yes ☐ No, date of last infusion: _____ Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

## DIAGNOSIS AND ICD-10 CODE

☐ Relapsing-remitting multiple sclerosis (G35.A)
☐ Primary progressive multiple sclerosis, unspecified (G35.B0)
☐ Primary progressive multiple sclerosis, active (G35.B1)
☐ Primary progressive multiple sclerosis, non-active (G35.B2)
☐ Secondary progressive multiple sclerosis, unspecified (G35.C0)
☐ Secondary progressive multiple sclerosis, active (G35.C1)
☐ Secondary progressive multiple sclerosis, non-active (G35.C2)
☐ Multiple sclerosis, unspecified (G35.D)

## REQUIRED DOCUMENTATION

☐ This signed order form by the provider
☐ Patient demographics AND insurance information
☐ H&P Clinical/Progress notes supporting primary diagnosis
☐ Quantitative serum immunoglobulin
☐ Labs and Tests supporting primary diagnosis
☐ Hepatitis B Test Results: HBsAg & Total HepB Core Antibody
☐ TB Test Results

Current MS treatment and end of current therapy date: _____

## PREMEDICATION ORDERS

☐ Acetaminophen PO ☐ 500mg ☐ 650mg ☐ 1000mg
☐ Diphenhydramine PO ☐ 25mg ☐ 50mg
☐ Methylprednisolone IV ☐ 40mg ☐ 100mg ☐ _____mg
☐ Other: _____

## MEDICATION ORDERS

| | |
|---|---|
| Initial Dosing | ☐ Briumvi 150mg IV x 1 dose then 450mg IV 2 weeks after first infusion |
| Maintenance Dosing | ☐ Briumvi 450mg IV every 24 weeks (to begin 24 weeks from first infusion) |

Refills*: ☐ X 6 months ☐ X 1 Year ☐ Other: _____

*** Infusions will be titrated to maximum recommended rate as suggested in prescribing information.*

☐ RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline
☐ RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration
☐ RN to flush and lock VAD/CVAD per company protocol

Other: _____

Observe patient for 60 minute post infusion of first two infusions. If no infusion reaction or hypersensitivity has been observed, patient is not required to stay for subsequent infusions.

## EMERGENCY MEDICATIONS

☐ Administer the following medications as needed for infusion-related reactions per company protocol:

**Adults (weight >40kg):**

Diphenhydramine 25mg-50mg PO
Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
Acetaminophen 325mg-650mg PO
Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.3mg IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

**Pediatrics (weight <40kg): (may adjust with weight changes)**

Diphenhydramine 25mg PO
Diphenhydramine 25mg slow IV push over 2-5 mins
Acetaminophen 325mg PO
Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x 1 if hypotensive

Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

## PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____

Office Phone: _____ Office Fax: _____

Prescriber Signature: _____ Date: _____

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