Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Briumvi® (ublituximab-xiiy) Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:			
Patient Name:		Address:			
Date of Birth:		City, State, Zip:			
Height in inches:	Weight: LB or KG	Gender:	Allergies:	☐ See list	☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

- ☐ G35 - Relapsing Remitting Multiple Sclerosis
- ☐ G35 - Primary Progressive Multiple Sclerosis
- ☐ _____- Other:

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	**REQUIRED:** Hepatitis B panel for new start patients		☐ **Continue current order until insurance approved**
6	Quantitative Serum Immunoglobulin screening		

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive ubituximab-xiiy if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new onset or deterioration neurological changes, and/or surgery. It is recommended to periodically monitor serum Ig levels. The patient should be made aware of the risks of becoming pregnant while taking ubituximab-xiiy and it is recommended that they be monitored for pregnancy during treatment.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

*Per FDA labeling, an antipyretic, antihistamine, and methylprednisolone IVP is suggested prior to infusion.

IV	Diphenhydramine	☐ 25mg	☐ 50mg						
	Methylprednisolone	☐ 40mg	☐ 125mg	☐ Other:					
	Famotidine	☐ 20mg	☐ 40 mg						
	Other:	☐							
PO	Acetaminophen	☐ 325mg	☐ 500mg	☐ 650mg	☐ 1000mg				
	Famotidine	☐ 20mg	☐ 40mg						
	Diphenhydramine	☐ 25mg	☐ 50mg						
	Fexofenadine	☐ 60mg	☐ 180mg						
	Cetirizine	☐ 10mg							
	Loratadine	☐ 10mg							
	Other:	☐							

MEDICATION/FREQUENCY:

☐ **Induction:**

Week 0 dose: Briumvi® 150mg IV in 250ml NS administered over 4 hours per step protocol

Week 2 dose: Briumvi® 450mg IV in 250ml NS administered over 1 hour per step protocol

☐ **Maintenance:**

Briumvi® 450mg IV per 250ml NS administered over 1 hour per step protocol every 24 weeks

One-hour post observation period following the first two infusions.

☑ Refills x 12 months unless noted otherwise here:

***Maintenance dosing is scheduled 24 weeks from initial 0-week dosing.**

SPECIAL/LAB ORDERS:

☐ _____

_____

LINE USE/CARE ORDERS:

- ☑ Start PIV/Access CVC
- ☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	