

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

Briumvi® (ublituximab-xiyy) 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	Quantitative Serum Immunoglobulin screening		Continue current order until insurance approved
6	REQUIRED: HBsAg, anti-HBc, and anti-HBs		

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive ubituximab-xiyy 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-xiyy 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	Other:	PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg			Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					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.

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