BRIUMVI™ (UBLITUXIMAB-XIIY) PRESCRIBER ORDER FORM

Patient Name:	**Date of Birth:**	**Gender:**
Address:		

Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**
Quantitative Serum IG Levels:	**Hepatitis B Status:** Titer Date: ☐ Positive ☐ Negative

Briumvi™ (Ublituximab-xiiy) Prescription

Initial Dose:

☐ **Infuse 150 mg IV over at least 4 hours using titrated rate on day 1**
Start at 10 mL/hr for the first 30 min. Increase to 20 mL/hr for 30 min. Increase to 35 mL/hr for 60 min. Increase to 100 mL/hr per for the remaining 2 hours

☐ **Infuse 450mg IV over 1 hour using titrated rate two weeks after the first infusion**
Start at 100 mL/hr for the first 30 min, then increase to 400 mL/hr for the remaining 30 minutes

☐ Other: _____

Maintenance Dose:

☐ **Infuse 450 mg IV over 1 hour using titrated rate 24 weeks from initial infusion and every 24 weeks thereafter. Refill as directed x 1 year.**
Start at 100 mL/hr for the first 30 min, then increase to 400 mL/hr for the remaining 30 minutes

☐ Other: _____

If planned maintenance dose is missed, administer dose ASAP and reset dosing schedule to six months after the missed dose was administered. Maintenance doses must be separated by at least 5 months.

Ancillary Orders

Anaphylaxis Kit

- Epinephrine 0.3 mg SQ or IM x 1 dose & repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25mg IV or IM; may repeat x 1 dose in 15 min PRN if no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Medication Orders

☐ Methylprednisolone sodium succinate 100 mg IV 30 min prior to infusion.
☐ Diphenhydramine _____mg PO 30 min before infusion.
☐ Acetaminophen _____mg PO 30 min before infusion. Patient may decline.
☐ Other: _____

IV Flush Orders

☐ Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.
☐ Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

☐ No labs ordered at this time.
☐ Quantitative serum IG level every 6 months to be drawn at maintenance dose infusion visit.
☐ Other: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:	**NPI:**	
City, State: **Zip:**	**Office Contact:**	

Fax completed form, insurance information, and clinical documentation to:

