

BRIUMVI® (ublituximab-xiyy)


Patient Information

Full Name: _____ Weight: _____ lbs kg Height: _____
 DOB: _____ Allergies: NKDA _____
 Phone Number: _____
 Patient Status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

Required Documentation

- Patient Demographics and Insurance Card Medication List Quantitative serum immunoglobulin screening
 Clinical/Progress Notes Supporting Dx Hep B Status Results

Primary Diagnosis

-  ICD-10 Code (required): _____
 Multiple Sclerosis Secondary Progressive MS
 Relapsing Forms of Multiple Sclerosis Other: _____

Pre-Medication

- Per violet health protocol: acetaminophen 650 mg PO, diphenhydramine 25 mg IV, methylprednisolone 125 mg IV given 30 minutes prior to infusion 
 Other: _____
 Acetaminophen (Tylenol) PO 500mg 650mg 1000mg
 Diphenhydramine (Benadryl) 25mg 50mg PO IV
 Methylprednisolone (Solu-Medrol) IV 40mg 125mg
 Cetrizine (Zyrtec) 10 mg PO

Therapy Administration

Induction dosing:

- Briumvi 150 mg IV at week 0, followed by 450 mg IV at week 2, followed by 450 mg IV at week 2+

Maintenance dosing:

- Briumvi 450 mg IV every 24 weeks

Refills:

- x 1 year Other: _____  Order valid for one year unless otherwise stated

Nursing Orders

- RN to flush and lock VAD/CVAD per violet health protocol (see violetinfusions.com/ protocol for policy) Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy) **Other: Please fax alternative reaction orders, flush orders, or nursing administration orders if checking this box**
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration. RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines.

Lab Orders

- CBC at each dose every _____ CRP at each dose every _____
 CMP at each dose every _____ Other: _____

Provider Information

Provider Name: _____ Office Contact Person: _____
 Referring Practice Name: _____ Phone Number: _____
 Referring Practice Address: _____ Fax Number: _____
 City, State, Zip: _____ Email: _____
 Provider NPI: _____
 Provider Signature: _____ Date: _____