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: _____

REV: 6/2025

Gaylord, MI
Phone: (989) 619-6253
Fax: (855) 857-3834

Traverse City, MI
Phone: (231) 252-0893
Fax: (855) 857-3834

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Phone: (906) 661-1088
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