Ublituximab-xiiy(Briumvi)

Provider Order Form rev. 09/18/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

☐ G35.A Relapsing-Remitting MS ☐ G35.B0 Primary Progressive MS, Unspecified ☐ G35.B1 Active Primary Progressive MS

☐ G35.B2 Non-Active Primary Progressive MS ☐ G35.C0 Secondary Progressive MS, Unspecified ☐ G35.D MS, Unspecified

☐ G35.C1 Active Secondary Progressive MS ☐ G35.C2 Non-Active Secondary Progressive MS ☐ Other:

THERAPY ADMINISTRATION

☐ Induction Week 0: Administer Briumvi 150mg diluted in 250ml NS and infused over 4 hours *(infusion rates below)*

☐ Induction Week 2 & week 24: Administer Briumvi 450mg diluted in 250ml NS and infused over 1 hour *(infusion rates below)*

☐ Maintenance: Administer Briumvi 450mg every 24weeks diluted in 250ml NS and infused over 1 hour

☑ Monitor Patient for 60mins after the first 2 infusions

DOSING REFERENCE

Infusion	150mg dose (Duration at least 4 hours)	450mg dose (Duration at least 1 hour)
0	10 ml/hr x30mins	100ml/hr x 30mins
30 min	20 ml/hr x30mins	400ml/hr x 30mins
60 min	35ml/hr x60mins	
120 min	100 ml/hr x120mins	

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ CBC w/ diff ☐ at each dose ☐ every: _____

☐ CMP ☐ at each dose ☐ every: _____

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO

☐ Loratadine 10mg PO

☐ Pepcid 20mg ☐ PO / ☐ IVP

☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP

☐ Solumedrol ☐ 40mg / ☐ 125mg IVP

☐ Other: _____

☑ All pre-medication needs to be administered 30 minutes prior to infusion

NURSING

☑ Hold infusion and notify provider for:

- Active HepB
- Signs/symptoms of infection
- Recent live vaccines
- POSITIVE pregnancy test

☑ Monitor vital signs with every rate change, then every 60 minutes and prior to discharge

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, MRI results

Required Labs: Negative Hepatitis B, Quantitative Immunoglobulin lab results, Negative pregnancy test, JCV

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.