aleracare
advanced infusion centers™

FAX 833.329.4738

Briumvi (ublituximab-xiiy)

Provider Order Form rev. 7/10/2023

Patient Information

Patient Name: DOB:

Patient Phone: Patient Email:

◯ NKDA ◯ Allergies: Weight lbs/kg: Height:

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Last infusion date (if applicable): _____

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No Does the patient need interpreter services: ◯ Yes ◯ No

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

ICD-10 CODE

◯ G35 Multiple Sclerosis ◯ Other: _____

Medication Order

Briumvi (ublituximab-xiiy)

Initiation Therapy:

◯ 150mg IV for first infusion

◯ 450mg IV 2 weeks after the first infusion

◯ 450mg IV 24 weeks after the first infusion and then 24 weeks thereafter

Maintenance Therapy:

◯ 450mg IV every 24 weeks

Documentation Required (Note: Send all labs, must include specific labs listed here)

◯ **Labs:** Hepatitis B; Quantitative Serum immunoglobulins ◯ Insurance Card (front and back)

◯ Current Medications ◯ History/Progress Notes

Pre-Medication Order

methylprednisolone (Required; give 30min before infusion) ◯ 100mg IV **loratadine** (Claritin) ◯ 10mg PO

acetaminophen (Tylenol) ◯ 500mg ◯ 650mg ◯ 1000mg PO **diphenhydramine** (Benadryl) ◯ 25mg IV ◯ 50mg IV

cetirizine (Zyrtec) ◯ 10mg PO

Other: _____

Dose:_____ Route:_____ Frequency: _____

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

Provider Name **Provider Signature** **Date**

Order Expiration Date (mm/dd/yy): _____ (If not indicated order will expire one year from date signature) Check here if this is a stat order ◯