

Patient Information

Patient Name:		DOB:	
Patient Home Phone:	Patient Cell Phone:	Patient Email:	
Emergency/Alternate Contact Name:		Emergency/Alternate Contact Phone:	
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:	Maintenance Therapy:
	150mg IV for first infusion Qty: 1 vial	450mg IV every 24 weeks Qty: 3 vials
	450mg IV 2 weeks after the first infusion Qty: 3 vials	
	450mg IV 24 weeks after the first infusion and then 24 weeks thereafter Qty: 3 vials	

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: _____	

Line/Port Use Orders

RN to start/discontinue peripheral IV or access/de-access port

RN to administer 3-10 mL normal saline with heparin 100 units/mL 1-5 mL per SASH method

Do NOT administer heparin to this patient

Additional orders: _____

Adverse Reaction and Anaphylaxis Orders

Standard anaphylaxis kit (EPINEPHrine 0.3 mg IM PRN for severe reactions x 1, may repeat once within 5-15 minutes for a maximum of 2 doses; Benadryl 50 mg PO PRN for mild-moderate reactions x 1; Benadryl 50 mg IV PRN for mild-moderate reactions x 1)

Additional orders: _____

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

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

Provider Signature
Date

Check here if this is a stat order