Patient Name: _____ DOB: ___/___/_____

Date of Last Infusion: ___/___/_____ Height_____ Weight_____

Infusion Location: (state and Site) _____

Brumvi® (Ublituximab) Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):	
_____ Multiple Sclerosis (ICD-10)	_____ Other: _____ (ICD-10)

Hold Infusion and Notify MD for:

- Signs/symptoms of infection
- recent live vaccines
- POSITIVE pregnancy test

Documentation Needed:

- ❑ Hepatitis B vaccination record to negative lab results
- ❑ Quantitative Immunoglobulin lab results
- ❑ Office visit notes with currently lab results and treatment failure list
- ❑ Negative pregnancy test

Pre-medications (To be administered once *30 minutes prior* to infusion):			
❑ Tylenol 500mg PO	❑ Pepcid 20mg PO or IV	❑ Benadryl 25-50mg PO or IV	❑ Solumedrol 100mg IV
❑ Other:_____			

Dosing:

- ❑ INDUCTION:
- ❑ Briumvi **150mg at week 0** diluted in 250ml NS and infused over 4 hours (infusion rates below)
- ❑ Briumvi **450mg at week 2 & week 24** diluted in 250ml NS and infused over 1 hour (infusion rates below)

- ❑ Maintenance:
- ❑ Briumvi **450mg every 6months** (24weeks) diluted in 250ml NS and infused over 1 hour

Administration:

- Monitor vital signs with every rate change, then every 60 minutes and prior to discharge
- Slow or stop infusion if reaction occurs and initiate the Hypersensitivity Reaction Management Protocol.

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 x 60mins	
120 min	100 ml/hr x 120mls	

Lab orders:		
❑ CBC with diff	❑ CMP	Other:

Additional Orders:

Provider name (print)_____ Date:_____

Provider signature: _____ Time: _____

Reviewed 2/16/23. 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.

Patient Name: _____ DOB: ___/___/_____

Date of Last Infusion: ___/___/_____ Height_____ Weight_____

Infusion Location: (state and Site) _____

Provider name (print)_____ Date:_____

Provider signature: _____ Time: _____