Ublituximab-xiiy (Briumvi) Patient Referral Form

Patient Demographics Information

Patient Name		SSN#	DOB
Patient Address			
Primary Phone	Cellular Phone	Work Phone	
Emergency Contact Name, Relationship		Emergency Contact Phone Number	

Additional Documentation Needed

- Copy of insurance cards
- Patient face sheet w/demographics
- History and Physical
- CBC w/dif, BMP, & CMP
- Recent vitals including blood pressure
- Screening for HBV infection

Patient Insurance Information

Insurance Plan #1			Insurance Plan #2		
Subscriber Name		DOB	Subscriber Name		DOB
Policy Number	Group ID		Policy Number	Group ID	

Patient Clinical Information

Gender ☐M ☐F	Height (inches)	Weight (lbs)	Allergies (food/drug)

Statement of Medical Necessity / Primary Diagnosis

ICD10:

Description of diagnosis:

Medication Information / Prescription and Orders

Medication

Briumvi

Directions

Infuse IV per manufacturer guidelines **OR** over ______ hours.
Titration rate according to package insert.

***If subsequent treatment cycles only**

Date of last infusion:

Next dose due:

☐ First Infusion
150 mg IV day 1, #1 dose, no refill

☐ Second Infusion (2 weeks later) and Subsequent Infusions
450 mg IV 2 weeks following first infusion and then every 24 weeks thereafter, #2 doses, refill x12 months OR

☐ Other ________________

Line Access

RN to start peripheral IV or use existing CVAD. RN to administer catheter flushing and medications as ordered.

☐ Sodium Chloride 0.9% 10 mL Flush: Flush with 2-10 mL sodium choride 0.9% IV before and after medication administration or every 24 hours while IV access in place.

☐ Sodium Chloride 0.9% 10 mL STERILE Flush: Flush with 5-10 mL STERILE sodium chloride 0.9% IV as needed for port access.

☐ Heparin Lock 100U/mL 5 mL Flush: Lock with 5 mL heparin 100U/mL after each use or daily while port is accessed.

Quantity/Refills

Dispense:
Quantity #QS + PRN refills unless otherwise noted

☐ Other

Premedications

☐ **Give premedication 30 minutes prior to infusion** *(generics will be dispensed)*

Diphenhydramine: ☐ 25-50 mg PO

Methylprednisolone: ☐ 125 mg slow IV push over 5 minutes

Acetaminophen: ☐ 325-650 mg PO **OR** ☐ ________ mg PO

☐ EMLA topical cream (Lidocaine 2.5% and Prilocaine 2.5%): apply to IV site prior to access PRN for pain upon needle insertion.

☐ Sodium Chloride 0.9% 500 mL - 1000 mL IV over 1-2 hours as tolerated daily PRN for hydration and/or headache.

☐ Other (Physician to specify):

Adverse Reaction Orders

In the event of an infusion reaction (ie: fever, chills, backache, headache, rigors) the following orders will be followed and physician will be notified.

- Mild reaction: Pause infusion for 10 minutes, resume infusion at a minumum 50% reduction in rate after symptoms have resolved.
- Moderate reaction: Pause infusion, administer diphenhydramine 25 mg IV; administer sodium chloride 0.9% 500mL IV bolus. If symptoms persist, administer remaining diphenhydramine 25 mg IV. Administer diphenhydramine IM if no IV access. Notify Pharmacist.
- Severe reaction (w/breathing problems): CALL 911, administer epinephrine IM 0.3 mg; administer diphenhydramine 50 mg IV x 1 dose; administer sodium chloride 0.9% 500 mL IV bolus. Administer diphenhydramine IM if no IV access.

Prescriber Information

Physician Name		Office Contact	
Practice Address		Practice Phone	
NPI#	License #	DEA#	
Physician Signature Required - Substitution Permitted	Date	Physician Signature Required - Dispense as Written	Date