BIG SKY IV CARE
Infusion Pharmacy & Nursing
An Access Infusion Care Company

UBLITUXIMAB-XIIY ORDERS (Briumvi)

REFERRAL CHECKLIST
Please ensure the following information is included with your referral:
☐ Patient Demographics and Contact Information
☐ Patient Insurance Information
☐ Completed H&P and Progress Notes Including Medications and Allergies
☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
☐ Documentation of contraceptive use (if applicable)
☐ Completed and Signed Referral
☐ Recent CBC wdiff and CMP results, recent TB/HepB testing
Primary Dx Codes: G35.A Relapsing-remitting multiple sclerosis G35.B0 Primary progressive multiple sclerosis, unspecified G35.B1 Primary progressive multiple sclerosis, active G35.B2 Primary progressive multiple sclerosis, non-active
G35.C0 Secondary progressive multiple sclerosis, unspecified G35.C1 Secondary progressive multiple sclerosis, active G35.C2 Secondary progressive multiple sclerosis, non-active G35.D Multiple sclerosis, unspecified
Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient. Thank you!

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Print, complete, and fax completed form to (406) 752-0443

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PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI:
City, State, Zip:	Address:
Cell: Email:	City, State, Zip:
Ht: Wt: kg Last 4 of SSN: DOB:	Phone: Fax:
Allergies:	Contact Person:

REFERRAL STATUS ☐ New Referral ☐ Continuation Order ☐ Dose or Frequency Change	
First dose? ☐ Yes ☐ No - Date of last infusion:	Line type: ☐PIV ☐PICC ☐Port ☐Other

DIAGNOSIS	
☐ Dx Code/description:	☐Secondary Dx Code/description:

REQUIRED DOCUMENTATION ☐ Signed order ☐ Demographics/insurance info ☐ H&P/labs/tests/progress notes supporting the Dx	
Prior Therapies:	
☐Documentation of Contraceptive use (if applicable)	
☐Quantitative serum immunoglobulin	☐TB Screening: ☐Positive ☐Negative-Date:
☐Current treatment/end of therapy date:	☐Hepatitis B Screening: ☐Positive ☐Negative-Date:

PRESCRIBING INFORMATION

LAB ORDERS

Frequency: Every Labs: ☐CMP ☐CBCwdif ☐CRP ☐Sed Rate ☐Hepatitis Panel
☐Quantitative IgG, IgA, IgE ☐ Lymphocyte Subset Panel ☐Other:

PREMEDICATIONS (administer 30 minutes prior to infusion) (recommended by manufacturer)

Acetaminophen: ☐650mgPO ☐1000mgPO	Methylprednisolone: ☐100mgIV ☐125mgIV ☐ mgIV
Diphenhydramine: ☐25mgPO ☐50mgPO ☐25mgIV ☐50mgIV	Other: ☐

MEDICATION

Medication	Strength	Dose/Directions	Quantity
☒**Ublituximab-xiiy (Briumvi)**	150mg/6mL	☐**Induction:**150mg on Day 1, 450mg on Day 15 ☐**Maintenance:**450mg every 24 weeks (begin 24 weeks after first induction dose) Infuse in 250ml 0.9%NS IV over 60 minutes	☐4 vials for induction doses ☐3 vials Refills:

If not specified, order will be valid for 1 year from the date of signature.

OBSERVATION

Observe the patient for at least 60 minutes after infusion #1 and #2. If no IRRs, no observation is required for subsequent infusions.

NURSING INSTRUCTIONS/EMERGENCY MEDICATION

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion:Use 50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/ 5mLHeparin 100u/mL(Port) final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only):1-6L/min via NC/face mask; titrate to maintain SpO_2 95-100%.

Prescriber Signature X: _____ **Date:** _____

☐**Product Substitution Permitted** ☐**Dispense as Written**

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