BARNES HEALTHCARE SERVICES

Briumvi™ (ublituximab-xiiy) Order Form

Please fax all pages of completed form to our Intake team at 888.276.7948
Contact our Intake team 800.422.5059 ext.1480

1 Patient Information — Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ **Last name** _____ **MI** _____
Preferred patient first name _____ **Preferred patient last name** _____
Sex at birth: ☐ Male ☐ Female **Gender identity** _____ **Preferred Pronouns** _____
Last 4 of SSN _____ **Date of birth** _____/_____/_____
Street address _____ **Apt #** _____
City _____ **State** _____ **Zip** _____
Home phone _____ **Cell phone** _____ **Email address** _____
Parent/guardian (if applicable)
Home phone _____ **Cell phone** _____ **Email address** _____
Alternate caregiver/contact
Home phone _____ **Cell phone** _____ **Email address** _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other **If other, please specify** _____

Provider will read the following statement to patient: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Barnes Healthcare Services about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

2 Prescriber Information — All fields must be completed to expedite prescription fulfillment.

Date _____ **Time** _____ **Date medication needed** _____/_____/_____
Office/clinic/institution name _____
Prescriber's first name _____ **Last name** _____
Prescriber's title _____ **If NP or PA, list under direction of Dr.** _____
Office phone _____ **Fax** _____ **NPI #** _____ **License #** _____
Office contact and title _____ **Office contact email** _____
Office street address _____ **Suite #** _____
City _____ **State** _____ **Zip** _____
Infusion location: ☐ Patient's home ☐ Prescriber office ☐ Infusion site

If infusion site, complete information below:

Infusion site name _____ **Clinic/hospital affiliation** _____
Site street address _____ **Suite #** _____
City _____ **State** _____ **Zip** _____
Infusion site contact _____ **Phone** _____ **Fax** _____
Email _____

Note: Check the appropriate shipment options in Section 4: Prescribing Information.

3 Clinical Information

Primary ICD-10 code (REQUIRED): ☐ Multiple Sclerosis: G35 ☐ Other _____
Laboratory results: LEVF _____
Hepatitis B screening date: _____/_____/_____
Immunoglobulins A/E/G/M quantitative screen date: _____/_____/_____
Pregnancy test (+/-) _____ **Date:** _____/_____/_____
First two loading doses completed: ☐ Yes ☐ No
Note: Briumvi loading doses must be administered in a controlled setting.
Expected date of first/next infusion: _____
☐ NKDA **Known drug allergies** _____
Concurrent meds: _____

4 Prescribing Information

Medication	Dose	Directions	Qty/Refills/Ship To
Loading Doses (two infusions) — Briumvi™ (ublituximab) 150mg/6mL single-use vials			
First loading dose: 150mg/6mL single-use vials diluted in NS to a final concentration of 0.6mg/mL	150mg/6mL single-use vial (1 vial)	First loading dose: 150mg IV in 250mL of 0.9% NS. Withdraw 6mL from 0.9% NaCl 250mL bag and discard. Add 6mL (150mg) of Briumvi into infusion bag. • Start at 10mL/hr for first 30 minutes • Increase to 20mL/hr for next 30 minutes • Increase to 35mL/hr for next hour • Increase to 100mL/hr for remaining 2 hours Duration: 4 hours	1 vial · No refills Note: Loading doses must be administered in a controlled infusion site. Ship to: ☐ Office ☐ Infusion Clinic ☐ Unknown
Second loading dose: Use three 150mg vials for total 450mg/18mL diluted in NS to final concentration of 1.8mg/mL	3 × 150mg/6mL single-use vials (450mg/18mL total)	Second loading dose (2 weeks later): 450mg IV in 250mL of 0.9% NS. Withdraw 18mL from bag and discard. Add 18mL (450mg) of Briumvi. • Start at 100mL/hr for first 30 minutes • Increase to 400mL/hr for remaining 30 minutes Duration: 1 hour	3 vials · No refills Ship to: ☐ Office ☐ Infusion Clinic ☐ Unknown
Maintenance Dose — Briumvi™ (ublituximab) 150mg/6mL single-use vials			
Maintenance: Use three 150mg vials for total 450mg/18mL diluted in NS to final concentration of 1.8mg/mL	3 × 150mg/6mL single-use vials (450mg/18mL total)	Infuse 450mg IV in 250mL of 0.9% NaCl every 6 months (from date of first loading dose). • Withdraw 18mL from 250mL bag; add 18mL (450mg) of Briumvi • Start at 100mL/hr for first 30 minutes • Increase to 400mL/hr for remaining 30 minutes Duration: 1 hour	3 vials · 1 refill Ship to: ☐ Home ☐ Office ☐ Infusion Clinic ☐ Unknown

All Briumvi™ orders to be administered via pump and peripheral line unless otherwise instructed.

5 Additional Prescribing Information for Home or Site Infusions

Premedication Orders

☐ Acetaminophen 650mg PO 30 min prior to infusion; Diphenhydramine 50mg PO 30 min prior to infusion; Methylprednisolone 100mg IV 30 min prior to infusion

☐ Other _____

Send quantity sufficient for medication infusion. All caregivers and ancillaries to be given per protocol from product package insert. If patient requires specific directions on additional medications or supplies, please provide change on the next page and sign.

Fluids for Reconstitution and Administration

☐ 0.9% NaCl 250mL

☐ 0.9% NaCl Flush 10mL (3mL pre- and post-infusion to maintain peripheral line patency.)

☐ 0.9% NaCl 50mL

☐ 0.9% NaCl 100mL

Hypersensitivity / Anaphylaxis Orders

In the event of anaphylactic reaction, stop infusion of drug immediately. Start NS 15mL/hour; 0.9% NS 100mL. Medicate with epinephrine pen auto-injector 0.3mg/0.3mL IM as needed for anaphylaxis. Call *911*, physician, or paramedic.

Lab orders _____ **Frequency** _____

I authorize ancillary supplies or medical equipment necessary such as needles, syringes, etc. to administer the therapy as needed for administration. (S9359, S9379)

Skilled nursing visit(s) as needed to establish venous access, administer medication and assess general status and response to therapy (99601, 99602)

**If nursing services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.*

Prescriber's signature required (below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE	

Date _____ ☐ **Dispense as written** **Date** _____ ☐ **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

6 Additional Medications for Home Infusion Protocol as Per Pkg Insert

If your patient requires individualized dosing or administering, please cross out directions below, provide desired directions in the box and sign.

Date _____ **Signature** _____

Medication	Dose	Directions
Diphenhydramine IV 50mg/1mL (25mg)	25mg	30 minutes prior to infusion, withdraw 0.5mL and inject into 50mL 0.9% NS. Infuse IV 101mL/hour over 30 min.
Diphenhydramine IV 50mg/1mL (50mg)	50mg	30 minutes prior to infusion, withdraw 1mL and inject into 50mL 0.9% NS. Infuse IV 102mL/hour over 30 min.
Methylprednisolone IV 100mg and Diphenhydramine PO	100mg	30 min prior to infusion, activate vial, withdraw 1.6mL/100mg, inject into 50mL 0.9% NS. Infuse IV 104mL/hour over 30 minutes.
Methylprednisolone IV 100mg and Diphenhydramine IV SIG	100mg	Activate vial, withdraw 1.6mL/100mg. Inject 100mg (1.6mL) IV push 0.2mL/min for 8 minutes; may increase to 0.4mL/min for 4 min based on absence of infusion reactions, 30 minutes prior to infusion.
Methylprednisolone IV 125mg SIG	125mg	30 minutes prior to infusion, activate vial, withdraw 2mL/125mg, inject into 100mL 0.9% NS. Infuse IV 204mL/hour over 30 minutes.
Methylprednisolone IV 250mg SIG	250mg	30 minutes prior to infusion, activate vial, withdraw 4mL/250mg, inject into 100mL 0.9% NS. Infuse IV 208mL/hour over 30 minutes.
Methylprednisolone IV 500mg SIG	500mg	30 min prior to infusion, activate vial, withdraw 8mL/500mg, inject into 100mL 0.9% NS. Infuse IV 216mL/hour over 30 minutes.
Methylprednisolone IV 125mg vial and Bacteriostatic water	125mg	Reconstitute Methylprednisolone 125mg with 2mL Bacteriostatic water for injection. Withdraw 1.6mL/100mg. (a) Inject 100mg (1.6mL) IV push 0.2mL/min for 8 min; may increase to 0.4mL/min for 4 min based on absence of infusion reactions, 30 min prior to infusion. (b) Withdraw 1.6mL and inject into 50mL 0.9% NS. Infuse IV 104mL/hour over 30 minutes, 30 minutes prior to infusion.
Famotidine IV 20mg	20mg	30 minutes prior to infusion, withdraw 2mL and inject into 100mL 0.9% NS. Infuse IV 204mL/hour over 30 minutes.
Famotidine IV 10mg	10mg	30 minutes prior to infusion, withdraw 1mL and inject into 100mL 0.9% NS. Infuse IV 202mL/hour over 30 minutes.