Atrium Health

Atrium Health Infusion Center

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Infusion Center Concord **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Pineville **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Southpark **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Huntersville **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Kenilworth, a facility of CMC **Fax:** 704-512-5390 ☐ Atrium Health Infusion Center Abbey Place, a facility of CMC **Fax:** 704-512-5390 ☐ Atrium Health Infusion Center Cabarrus, a facility of CMC **Fax:** 704-512-5390

Briumvi® (ublituximab-xiiy) Infusion Order (Revised 11/3/2025)

All orders with a √ will be placed.

Patient Demographics:		
Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:
Allergies: (please list all allergies or attach list) ☐ NKDA		

Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)	
☐ G35.A - Relapsing Remitting Multiple Sclerosis (RRMS)	☐ G35.C1 - Secondary Progressive MS (SPMS)
☐ Other:	

Required Documentation: (*required prior to scheduling*)	
Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion: Next infusion due date:
Complete Medication List - Include all tried and failed meds	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
Pertinent Diagnostic Studies to Ordered Medication	☐ Yes ☐ No

Labs:
☑ Urine Pregnancy Test (females of reproductive potential) prior to each infusion

Treatment Parameters:
☑ Hold treatment and notify provider IF: - Temperature is GREATER THAN 100oF; - Patient complains of symptoms of acute viral or bacterial infection; - Patient is taking an antibiotic for current infection.
☑ Required Lab Results: Hep B Profile, CBC with diff, CMP, Quantitative IgG level PRIOR to FIRST treatment (within 90 days). (**Fax labs with order**)
☑ Hold Tx and Notify Provider IF: - Hep B Panel: POSITIVE or not on file; - Quantitative IgG level: Not on file; - Urine Pregnancy Test: POSITIVE or not on file (females of reproductive potential); - CBC with diff and CMP: Not on file.

Nursing Communication:
☑ Start PIV/Access CVC and flush device per approved Atrium Health protocol.
☑ Vital Signs: For the first infusion, obtain vital signs pre- and post-infusion and every hour during infusion. For the second and subsequent infusions, obtain vital signs pre- and post-infusion and PRN during infusion.
☑ Monitor patient for signs of reaction for 1 hour after completion of first two infusions. Observe for 1 hour after subsequent infusions PRN if infusion reaction or hypersensitivity observed.

Pre-Medications: (Administer all pre-medications 30mins prior to treatment)
☐ Acetaminophen (Tylenol) 1000mg PO ONCE
☐ Diphenhydramine (Benadryl) 50mg PO ONCE
☐ Diphenhydramine (Benadryl) 50mg IV ONCE
☐ Loratadine (Claritin) 10mg PO ONCE
☐ Methylprednisolone sodium succinate (Solu-Medrol) 125mg IV ONCE

Infusion Therapy:
☐ Ublituximab-xiiy (Briumvi) 150mg IV - Wk 0
☐ Ublituximab-xiiy (Briumvi) 450mg IV - Wk 2
☐ Ublituximab-xiiy (Briumvi) 450mg IV every 24 weeks

Supportive Care Medications:
☑ Acetaminophen (Tylenol) 650mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give first if not given as a pre-medication.
☑ Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give second after acetaminophen.
☑ Ondansetron (Zofran) 4mg IV ONCE PRN nausea/vomiting.

Hypersensitivity Protocol:
☑ Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.

Prescriber Information:	
Provider Name:	Phone: Fax:
Practice Name:	NPI:
Address:	Office Contact:
City, State, Zip:	Office Contact Phone Number:

Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted	
Signature:	Date: