

**ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN**

**Allergies/Reactions:**

Fax all infusions to: 833-380-8800  
Please mark the appropriate infusion center:

- Allenmore Infusion Center
- Auburn Infusion Center
- Gig Harbor Infusion Services
- Puyallup Infusion Center
- DHEC Infusion Center
- North Spokane Infusion Center
- North Star Lodge Infusion Center

**ORDERS WITH CHECK BOXES**

When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

**Ublituximab (Briumvi):**

Patient Name: \_\_\_\_\_ Requested Date of Service: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  May leave message

**Diagnosis:**

Multiple Sclerosis

**ICD -10 Code:**

\_\_\_\_\_

**Required:** H&P with documentation to support above diagnosis including ICD-10 code and supporting labs and documentation  
*\*\*If required documentation not received with order, scheduling of treatment will be delayed until complete information is available\*\**

**Baseline Labs Required:**

- Hepatitis B
- Quantitative serum immunoglobulins
- Pregnancy test
- CBC/CMP

**Maintenance labs required:**

- Pregnancy testing prior to each dose in patients' who may become pregnant
- CBC/CMP prior to each infusion

**IV Access:** Access and/or maintain IV site in accordance with MHS IV Therapy P&P: Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal.

**Premeds:**

- Methylprednisolone 100 mg IVP
- Diphenhydramine 25 mg IVP
- Acetaminophen 650 mg PO prn

**Treatment Regimen:**

Ublituximab (Briumvi) 150 mg IV x 1 on day 1, followed by 450 mg IV once 2 weeks later; subsequent doses of 450 mg IV once every 24 weeks (beginning 24 weeks after the first dose of 150 mg)

**Vital signs:** Check vital signs prior to and at completion of infusion.  
Contact provider if systolic BP>180; diastolic BP>100; systolic BP<90; HR >110; temp >38C (100.4F)

**If Hypersensitivity reaction (fever, chills, hypotension, rigors, itching, rash, etc.)**

- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for further orders

**Code Status:** Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

**Was consent obtained:**  Yes  No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Another brand of drug, identical in form and content, may be dispensed unless checked

**Orders expires in 12 months\*\***

**Notice of Language Availability – FREE Interpreter Service:**

MultiCare offers interpreter services for all languages at no cost to you. If your language is not listed, MultiCare will still provide interpreter services at no cost to you.



**Patient Identification - Always Attach Patient Label**

Name: \_\_\_\_\_  
MRN #: \_\_\_\_\_  
CSN #: \_\_\_\_\_  
Age / Sex and Gender: \_\_\_\_\_

Pre-printed Order  
**MULTIPLE SCLEROSIS**

