

Ublituximab-xiyy (Briumvi)

Provider Order Form rev. 1/25/2026



- Saint Cloud, FL
- Lake Mary-Sanford, FL
- Nashville, TN
- Gallatin, TN

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ DOB: _____

ICD-10 code (required): _____ ICD-10 description: _____

NKDA Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

NURSING

- Hepatitis B status & date (list results here & attach clinicals)

- Provide nursing care per IVCare Infusion's Nursing Procedures, including reaction management and post-procedure observation.

Based on the manufacturer PI, most payors require a quantitative serum immunoglobulin screening prior to Briumvi induction.

- I have attached results from a recent quantitative serum immunoglobulin test (list results here & attach clinicals):

- I instruct IVCare Infusion to draw quantitative serum immunoglobulin prior to first induction infusion (if required by payor).

THERAPY ADMINISTRATION

- Ublituximab-xiyy (Briumvi) intravenous infusion Induction: Dose: 150mg in 250ml 0.9% NS over four hours followed by 450mg in 250ml 0.9% NS over one hour two weeks later.**
Afterinduction, continue with the maintenance dosing and schedule below.
- Maintenance: Dose: 450mg in 250ml 0.9%NS over one hour 24 weeks after the first infusion and every 24 weeks thereafter.**
- Flush with 0.9% NS at the completion of infusion
- Patient required to stay for 60 minute observation post infusion of first two infusions. If no infusion reaction or hypersensitivity has been observed, patient is not required to stay for subsequent infusions.
- Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- CRP at each dose every _____
- Other: _____

PRE-MEDICATION ORDERS

The following are manufacturer recommended premedication regimens:

- acetaminophen (Tylenol) 500mg / 650mg / 1000mg PO
- methylprednisolone (Solu-Medrol) 40mg / 125mg IV
- diphenhydramine (Benadryl) 25mg / 50mg PO / IV

ADDITIONAL PRE-MEDICATION ORDERS

- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- Other: _____
Dose: _____ Route: _____
Frequency: _____

SPECIAL INSTRUCTIONS

Provider Name (Print) _____ Provider Signature _____ Date _____

TN

NASHVILLE

5501A NEW YORK AVE, NASHVILLE, TN. 37209
P: 615-475-5657 F: 615-475-5680

GALLATIN

710 NASHVILLE PIKE, STE 103, GALLATIN, TN. 37066
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FL

ST. CLOUD

2801 13TH STREET, ST. CLOUD, FL. 34769
P: 407-477-2345 F: 615-471-8674

LAKE MARY - SANFORD

344 W. LAKE MARY BLVD, SANFORD, FL. 32773
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