McLeod Health

Ublituximab (Briumvi) Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Patient Primary Phone Number: _____

Diagnosis:

☐ G35 Relapsing Remitting Multiple Sclerosis ☐ G35 Primary Progressive Multiple Sclerosis

☐ ICD 10 Code: _____ Diagnosis Description: _____

Pre-Medications: **administered 30 minutes prior to infusion**

● Acetaminophen 650 mg PO

● Diphenhydramine: Dose: ☐ 25 mg ☐ 50 mg Route: IVP

● Methylprednisolone: Dose: ☐ 40 mg ☐ 125 mg Route: IVP

☐ Other (include drug, dose, and route): _____

Drug Orders:

● Ublituximab (Briumvi) (J2329) as directed via IV infusion

☐ Induction: 150 mg IV on Week 0 and 450 mg IV on Week 2 per Sodium Chloride 0.9% 250 mL *(infused at initial rate of 20 mL/hr and increased up to a max rate of 100 mL/hr as tolerated)*

☐ Maintenance: 450 mg IV per Sodium Chloride 0.9% 250 mL once every 6 months for 2 doses *(infused at initial rate of 100 mL/hr and increased to 400 mL/hr after 30 minutes as tolerated)* *schedule first maintenance dose 24 weeks from Week 0 dose*

• Order Duration: One year unless otherwise specified (Other: _____)

Lab Orders:

☐ _____

Standing Orders:

● Monitor patient for 1 hour following completion of infusion

• Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

• Appropriate access and line care orders per health system policy

Physician Signature: _____ Date: _____

Physician Name: _____ Phone: _____

Approved: 12/2024; Last Reviewed: 01/26

Pre-Screening Requirements:

• Provide Hepatitis screening (Hepatitis B Surface Antigen and Total Hepatitis B Core Antibody) prior to start of therapy and within last 12 months.

Previous Therapies:

• For new patient referrals, please send history and physical and most recent physician note with completed plan

• If patient has previously received ublituximab at another facility, please provide last date received: _____

• If patient has previously received another biologic therapy, please provide the name: _____

and the last date received: _____

Insurance Information:

Insurance Plan Name: _____

Insurance Identification Number: _____

Insurance Customer Service Contact Number: _____

Preferred Treatment Location

☐ McLeod Regional Medical Center (Florence) ☐ McLeod Health Loris ☐ McLeod Health Cheraw

☐ McLeod Health Seacoast (Little River) ☐ McLeod Health Dillon ☐ McLeod Health Clarendon (Manning)

Fax completed Treatment Plan to the McLeod Medication Access Team at 843-777-9798. For any questions, please contact our team at medicationaccessteam@mcleodhealth.org.