



ADULT AMBULATORY INFUSION ORDER

3/2023

Ublituximab-xiyy (BRIUMVI) Infusion

NAME:
BIRTHDATE:
INSURANCE:
PROVIDER NAME:
CLINIC NAME and Phone number:

Patient identification

Weight: _____ kg Height: _____ cm Allergies: _____ Diagnosis Code: _____

Height & weight are required for a complete order. Treatment Start Date: _____

****If treatment not started within 90 days, new orders with updated date/signature will be required. Otherwise, orders are valid for 1 year from signature date.** GUIDELINES FOR ORDERING:**

- 1) Patient name and date of birth must be on EACH page of this order form. This form will be returned if any left blank.
- 2) Send FACE SHEET and complete copy of INSURANCE information. Send H&P or most recent chart note, must be within the past 12 months.
- 3) Send a copy of related lab results if not available for review in Epic.

REQUIRED Pre-screening labs: Results must be available prior to initiation of therapy, attach copy if not available in Epic. Select ONE of the CBC options below. If patient schedules after timeframe selected, we will redraw lab.

- CBC with differential to confirm WBC greater than 3.0. Results valid for 30 days. If results not available in Epic or included with this form, a standing order will be placed.
OR
- CBC with differential to confirm WBC greater than 3.0. Results valid for 60 days. If results not available in Epic or included with this form, a standing order will be placed. *(Recommended)*
- Hepatitis B screening: Hep B Core Antibody and Hep B Surface Antigen are recommended.

FOR FEMALE PATIENTS: Negative pregnancy test is required prior to receiving infusion.

- Check here ONLY If your patient **does not** need negative pregnancy test confirmed. If selected, please list reason for this decision: _____.

Optional PRE-MEDICATIONS: (Select all that apply, to administer 30 minutes prior to infusion.)

- MethylPREDNISolone sodium succinate (solu-MEDROL) 62.5 mg/mL injection 125 mg, iv.
- Acetaminophen (TYLENOL) tablet, 1,000 mg, oral.
- Cetirizine (zyrTEC) tablet, 10 mg, Oral.
- OR
- DiphenhydrAMINE (BENADRYL) tablet, 25 mg, oral.
OR
- DiphenhydrAMINE (BENADRYL) iv injection, 25 mg.

MEDICATION:

- Ublituximab-xiyy (BRIUMVI).** Keep in refrigerator. Mild to moderate infusion reactions: Reduce rate by half for 30 min, then resume titration. Severe infusion reactions: Stop infusion. Resume at half rate when symptoms resolve, then resume titration. Life threatening infusion reactions: Permanently discontinue.



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INTERVAL: (must select ONLY one)

Induction & maintenance doses:

- Day 0: 150 mg in Normal Saline 0.9% 250 ml IVPB. Infuse over 4 hours. Start at 10 mL/hr for 30 min; increase to 20 mL/hr for 30 min; increase to 35 mL/hr for 1 hr; increase to 100 mL/hr for remaining 2 hr. Observe patient for at least 1 hour after infusion.
- Day 14: 450 mg in Normal Saline 0.9% 250 ml IVPB. Infuse over 1 hour. Start at 100 mL/hr for 30 min; increase to 400 mL/hr for remaining 30 min. Observe patient for at least 1 hour after infusion.
- Maintenance dose: 450 mg in Normal Saline 0.9% 250 ml IVPB. Infuse over 1 hour. To be given after induction doses are completed, 24 weeks from date of first 150 mg infusion and every 24 weeks thereafter.
Start at 100 mL/hr for 30 min; increase to 400 mL/hr for remaining 30 min.

Maintenance dose only:

Date of last maintenance infusion:

- 450 mg in Normal Saline 0.9% 250 ml IVPB. Infuse over 1 hour. Give every 24 weeks. Start at 100 mL/hr for 30 min; increase to 400 mL/hr for remaining 30 min.

AS NEEDED MEDICATIONS:

- ✓ Sodium chloride 0.9% (NS) bolus 250 ml, Flush before and after IV medication(s) and as needed with NS.

Standard included Nursing Orders:

- ✓ Confirm prescreening tests are normal or have been addressed by LIP.
- ✓ Confirm WBC greater than 3.0. Confirm Hepatitis B screening addressed by LIP.
- ✓ Confirm that pregnancy test is negative (unless specified above not required).
- ✓ Insert peripheral IV if no iv access.
- ✓ May use/access CVC line and give 500 units (5ml) heparin injection for central line care.
- ✓ If hypersensitivity or infusion reactions develop, temporarily hold the infusion, and notify provider immediately. Include hypersensitivity reaction order set. (See attached form).

Mild to Moderate reactions:

1. Symptoms may include headache, flushing, scratchy throat.
2. Reduce rate by half for at least 30 minutes.
3. If tolerated, resume initial infusion titration rate.

Severe reactions:

1. Symptoms may include hypotension (systolic 80 or less, or 30 mmHg below baseline systolic), cardiac arrhythmia, dyspnea, facial and/or tongue swelling, or diffuse erythema.
2. Stop infusion immediately.
3. Resume at half rate when symptoms resolve, then resume titration.

HYPERSENSITIVITY INFUSION REACTION ORDERS

STOP infusion if:

MILD REACTION: Localized pruritus, rhinitis, localized rash, fever greater than 38 degrees C.

1. Stop infusion and maintain IV access with NS line.
2. Notify MD of symptoms and infusion reaction orders initiated.

MODERATE REACTION: Generalized pruritus, generalized flushing, rash, back pain, mild dyspnea, chills, hypotension with SBP less than 90 mmHg or greater than 20% decrease in SBP.



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1. Stop infusion, but do not discard infusion bag/bottle unless instructed by MD that therapy is to be discontinued.
2. Maintain IV access with NS line.
3. Place patients in a supine position with lower extremities elevated unless respiratory distress or nausea/vomiting.
4. Maintain airway.

SEVERE REACTION: Respiratory distress (bronchospasm, stridor, wheezing, persistent cough, respiratory depression, cardiac arrhythmia, chest pain, generalized urticaria (hives), syncope, gastrointestinal symptoms (abdominal pain, N/V, diarrhea), hypotension SBP less than 80 mmHg, face/throat/tongue swelling, shock, loss of consciousness.

1. Stop infusion, but do not discard bag/bottle unless instructed by MD that therapy is to be discontinued.
2. Stay with patient and have another nurse notify MD of symptoms and infusion reaction orders initiated.
3. Place patients in supine position with lower extremities elevated unless respiratory distress or nausea/vomiting.
4. Maintain airway.
5. Maintain IV access with NS line.
6. Inpatients: Activate code blue for loss of blood pressure, pulse, or consciousness.

MEDICATIONS:

- Acetaminophen (TYLENOL) tablet 650 mg, Oral, EVERY 4 HOURS PRN, Pain, Other, Mild reaction. Starting when released.
- Diphenhydramine (Benadryl) injection, 25 mg, Intravenous, EVERY 15 MIN PRN, Moderate or severe reaction, may repeat x1. Starting when released, For 2 doses.
- Methylprednisolone sodium succinate (solu-MEDROL) 62.5mg/ml injection, 125 mg, Intravenous, ONCE PRN, Severe reaction. Starting when released, For 1 dose. Mix with 2 mL provided diluent to make 62.5 mg/mL.
- Famotidine (PEPCID) injection 20 mg, Intravenous, ONCE PRN, Moderate reaction, or anaphylaxis, starting when released. Dilute 2 mL of famotidine with 8 mL of normal saline to a final concentration of 2 mg/mL. Administer ordered dose over a period of at least 2 minutes.
- Albuterol 90 mcg/puff inhaler 2 puff, Inhalation, ONCE PRN, Severe reaction p. Starting when released, For 1 dose. Shake well. Use with spacer.
- Start oxygen. For MODERATE Reaction: Start 2 liters O2 per nasal cannula as needed for SpO2 less than 93%. For SEVERE Reaction: Start continuous pulse oximetry. Administer 6 to 8 liters per minute (LPM) via face mask, or up to 100% oxygen to maintain oxygen saturation greater than 90%.
- EPINEPHrine 1 mg/mL injection 0.3 mg. Intramuscular, EVERY 5 MIN PRN, Anaphylaxis. Starting when released, For 3 doses. Administer in the anterior lateral thigh using 1 - 1.5-inch needle for airway obstruction symptoms and/or hypotension.
- Sodium chloride 0.9% (NS) infusion 500ml. At 500 mL/hr., Intravenous, PRN, Moderate reaction, or anaphylaxis. Starting when released. Run wide open to gravity.



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By signing below, I represent the following:

I am responsible for the care of the patient (*who is identified at the top of this form*).

I hold an active, unrestricted license to practice medicine in Oregon.

My physician license Number is # _____ and I am acting within my scope of practice and authorized by law to order infusion of the medications and blood products described above for the patient identified on this form.

Provider's printed name: _____

Provider's signature: _____

Date: _____

Please complete the following intake questions.

Mobility status

- Independent
- Walker
- Wheelchair
- Fully dependent

Bariatric needs

- Yes, briefly describe _____
- No

Transportation concerns

- Yes, briefly describe _____
- No

Interpreter Service required

- Yes, language _____
- No

Outpatient Infusion Services Intake Team:

Please check the appropriate box for the patient's preferred infusion center location:

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> PORTLAND | Phone-503-215-6046 Fax-503-487-3582 |
| <input type="checkbox"/> WILLAMETTE FALLS | Phone-503-215-6046 Fax-503-487-3582 |
| <input type="checkbox"/> MEDFORD | Phone-541-732-7000 Fax-541-732-3939 |
| <input type="checkbox"/> HOOD RIVER | Phone-541-387-6445 Call for fax # |
| <input type="checkbox"/> SEASIDE | Phone-503-717-7650 Fax-503-470-3146 |
| <input type="checkbox"/> NEWBERG | Phone-503-537-6040 Fax-503-205-8720 |