Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071

ADULT AMBULATORY INFUSION ORDER

Ublituximab (BRIUMVI) Infusion

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. Hepatitis B (Hep B surface antigen and core antibody total) screening must be completed prior to initiation of treatment and the patient should not be infected. Please send results with order.
3. A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order. If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order.
4. Serious, including life-threatening and fatal infections, have occurred. Delay ublituximab administration in patients with an active infection until the infection is resolved.
5. Vaccination with live attenuated or live vaccines is not recommended during treatment with ublituximab and after discontinuation, until B-cell repletion.
6. Monitor the level of immunoglobulins at the beginning, during, and after discontinuation of treatment with ublituximab, until B-cell repletion, and especially when recurrent serious infections are suspected. Consider discontinuing ublituximab in patients with serious opportunistic or recurrent serious infections, and if prolonged hypogammaglobulinemia requires treatment with intravenous immunoglobulins.
7. May cause fetal harm. Advise patients of childbearing potential of the potential risk to a fetus and to use effective contraception during treatment and for at least 6 months after stopping ublituximab.

PRE-SCREENING: (Results must be available prior to initiation of therapy):

- ☐ Hepatitis B surface antigen and core antibody test results scanned with orders.
- ☐ Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders.
- ☐ Chest X-Ray result scanned with orders if TB test result is indeterminate.

LABS:

- ☐ CBC with differential, Routine, ONCE, every visit
- ☐ Complete Metabolic Panel, Routine, ONCE, every visit
- ☐ IgG, Routine, ONCE, every visit
- ☐ IgM, Routine, ONCE, every visit
- ☐ CD19, Routine, ONCE, every visit
- ☐ HCG Qual, Urine, Routine, ONCE, every visit, for patients of childbearing potential

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NURSING ORDERS:

1. TREATMENT PARAMETER – Hold treatment and contact provider if Hepatitis B surface antigen or core antibody total test result is positive, TB test result is positive, or if screening has not been performed.
2. TREATMENT PARAMETER – Hold treatment and contact provider if there is an active infection.
3. TREATMENT PARAMETER – Hold treatment and contact provider if HCG urine test is positive.
4. **First infusion (150 mg):** Initiate infusion at 10 mL/hour for 30 minutes; if tolerated, increase to 20 mL/hour for 30 minutes; if tolerated, increase to 35 mL/hour for 60 minutes; if tolerated, increase to 100 mL/hour for the remainder of the infusion. Infusion duration: 4 hours.
5. **Subsequent infusions (450 mg):** Initiate infusion at 100 mL/hour for 30 minutes; if tolerated, increase to 400 mL/hour for the remainder of the infusion. Infusion duration: 1 hour.
6. Monitor for infusion reactions during infusion and observe for at least 1 hour after completion of first two infusions. Incidence is highest within 24 hours of the first infusion. Inform patients that infusion reactions may occur up to 24 hours after each infusion.
7. Mild to moderate reactions: Reduce infusion rate to 50% of the rate at which the reaction occurred. If tolerated for at least 30 minutes, return to original infusion rate titration until completion of infusion.
8. Severe reactions: Immediately stop infusion and administer supportive treatment. Following complete symptom resolution, restart infusion rate at 50% the rate at which the onset of the infusion reaction occurred. If tolerated, may return to original infusion rate titration as appropriate until completion of infusion.
9. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)
Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

- ☐ acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit
- ☐ diphenhydrAMINE (BENADRYL) capsule, 50 mg, oral, ONCE, every visit. ***Give either loratadine or diphenhydrAMINE, not both.***
- ☐ loratadine (CLARITIN) tablet, 10 mg, oral, ONCE AS NEEDED if diphenhydrAMINE is not given, every visit. ***Give either loratadine or diphenhydrAMINE, not both.***
- ☐ methylPREDNISolone sodium succinate (SOLU-MEDROL), 125 mg, intravenous, ONCE, every visit

MEDICATIONS:

- Ublituximab (BRIUMVI), 150 mg in sodium chloride 0.9%, intravenous, ONCE on day 1, followed by 450 mg in sodium chloride 0.9%, intravenous, ONCE 2 weeks later. Subsequent doses of 450 mg are administered ONCE every 24 weeks (beginning 24 weeks after the first dose of 150 mg).

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HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

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 ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

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OLC Central Intake Nurse:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

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

☐ **Beaverton**
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

☐ **NW Portland**
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

☐ **Gresham**
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

☐ **Tualatin**
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders