

# Ublituximab-xiiy (Briumvi)

**REFERRAL STATUS:**  New Referral  Dose or Frequency Change  Order Renewal

**Infusion Office Preference:** \_\_\_\_\_

## PATIENT INFORMATION

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 NKDA Allergies: \_\_\_\_\_ Weight (lbs / kg): \_\_\_\_\_ Height: \_\_\_\_\_  
Patient Status:  New to Therapy  Continuing Therapy - Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

## PROVIDER INFORMATION

Office Contact Name: \_\_\_\_\_ Office Email: \_\_\_\_\_  
Prescribing Providers Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_  
Office Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Office Phone Number: \_\_\_\_\_ Office Fax Number: \_\_\_\_\_

## DIAGNOSIS AND ICD 10 CODE

Relapsing-Remitting Multiple Sclerosis ICD-10 Code: G35  
 Secondary Progressive Multiple Sclerosis ICD-10 Code: G35  
 Primary Progressive Multiple Sclerosis ICD-10 Code: G35

## REQUIRED DOCUMENTATION/Testing

<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Labs and Tests supporting primary diagnosis
<input type="checkbox"/> Patient demographics AND insurance info	<input type="checkbox"/> Hepatitis B Test Results: HBsAg & Total HepB Core Antibody
<input type="checkbox"/> Clinical/Progress notes supporting primary dx	

Current MS treatment and end of current therapy date: \_\_\_\_\_

## PRE-MEDICATION ORDERS

acetaminophen (Tylenol)  650mg /  1000mg PO (prior to infusion)  
 diphenhydramine (Benadryl)  25mg /  50mg  PO /  IV (prior to infusion)  
 methylprednisolone (Solu-Medrol) 100 mg IV (prior to infusion)  
 other: \_\_\_\_\_

*Note: manufacturer recommended premedication regimen is Tylenol, Solu-Medrol and Benadryl*

## MEDICATION ORDERS

Initial Dosing	<input type="checkbox"/> Briumvi 150 mg IV x 1 dose then 450 mg IV at week 2
Maintenance Dosing	<input type="checkbox"/> Briumvi 450 mg IV every 24 weeks
Other Dosing :	<input type="checkbox"/> Briumvi _____ mg IV _____

Refills\*:  None  X6 months  X1 year  Other: \_\_\_\_\_

*\*(if not indicated order will expire one year from date signed)*

## SPECIAL INSTRUCTIONS

Urine pregnancy test prior to each infusion

Provider Name (Print) \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**All information contained in this order form is strictly confidential and will become part of the patient's medical record.**

**Contact us with questions at:** [877] 448-3627

**Send Completed Form and all documentation to:**

**Confidential email:** [Intake@Metroinfusioncenter.com](mailto:Intake@Metroinfusioncenter.com) or [866] 507-1164