

# Ublituximab-xiyy (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) PO  500mg  650mg  1000mg  
 diphenhydramine (Benadryl) PO / IV  25mg  50mg (if route is not circled PO will be administered))  
 methylprednisolone (Solu-Medrol) IV  60mg  100 mg  \_\_\_\_\_ mg  
 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:

**Fax referral to 866-507-1164 or email to [MICreferral@metroinfusioncenter.com](mailto:MICreferral@metroinfusioncenter.com)**

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