Briumvi (Ublituximab-xiiy)

MIC | METRO INFUSION CENTER

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	ICD-10 Code: G35		
☐ Secondary Progressive Multiple Sclerosis	ICD-10 Code: G35		

REQUIRED DOCUMENTATION/Testing	
☐This signed order form by the provider ☐ Patient demographics AND insurance info ☐Clinical/Progress notes supporting primary dx	☐Labs and Tests supporting primary diagnosis ☐Hepatitis B Test Results: HBsAg & Total HepB Core Antibody
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	☐ Briumvi 150 mg IV x 1 dose then 450 mg IV at week 2
Maintenance Dosing	☐ Briumvi 450 mg IV every 24 weeks
Other Dosing :	☐ 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

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

Revised 1/27/23