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 sclerosis	ICD-10 Code:	G35.A
☐ Active secondary progressive multiple sclerosis	ICD-10 Code:	G35.C1

REQUIRED DOCUMENTATION/Testing	
☐ This signed order form by the provider ☐ Patient demographics AND insurance info ☐ Clinical/Progress notes supporting primary dx ☐ Serum Quantitative Immunoglobulin Results	☐ Hepatitis B Test Results: Hep B surface Antigen & Hep B Core **TOTAL** Antibody ☐ Liver Function Test Results
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 (observe for one hour post infusion)
Maintenance Dosing	☐ Briumvi 450 mg IV every 24 weeks (to begin 24 weeks from first infusion) Post-infusion monitoring of subsequent infusions is at the physician's discretion. Pt will be released after infusion unless observation time is requested by ordering MD.
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

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 10/20/25

☐ Urine pregnancy test prior to each infusion

Provider Name (Print) **Physician Signature:** **Date:**