Briumvi

Provider Order Form

PATIENT INFORMATION

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Address: City: State: Zip Code:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

☐ NKDA ☐ Allergies: Weight lbs/kg: Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Therapy Change Last infusion date (if applicable):

DOCUMENTATION REQUIRED

☐ **Labs:** Hepatitis B; Quantitative Serum immunoglobulins

☐ **Current Medications**

☐ Insurance Card (front and back)

☐ History/Progress Notes

Multiple Sclerosis Type ☐ Relapsing-Remitting MS (RRMS) ☐ Primary-Progressive MS (PPMS) ☐ Secondary-Progressive MS (SPMS)

☐ Progressive-Relapsing MS (PRMS) ☐ Clinically Isolated Syndrome (CIS)

ICD-10 CODE

☐ G35.A Relapsing-remitting multiple sclerosis

☐ G35.B1 Active primary progressive multiple sclerosis

☐ G35.C0 Secondary progressive multiple sclerosis, unspecified

☐ G35.C2 Non-active secondary progressive multiple sclerosis

☐ G35.B0 Primary progressive multiple sclerosis, unspecified

☐ G35.B2 Non-active primary progressive multiple sclerosis

☐ G35.C1 Active secondary progressive multiple sclerosis

☐ G35.D Multiple sclerosis, unspecified

☐ Other: _____

PRE-MEDICATION ORDER

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO

Cetirizine (Zyrtec) ☐ 10mg PO

Loratadine (Claritin) ☐ 10mg PO

Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

Methylprednisolone (Solu-Medrol) ☐ 40mg IV ☐ 125mg IV

Hydrocortisone (Solu-Cortef) ☐ 100mg IV

Other: _____ Dose: _____ Route: _____ Frequency: _____

MEDICATION ORDER

Briumvi (ublituximab-xiiy)

Initiation Therapy:

☐ 150mg IV for first infusion

☐ 450mg IV 2 weeks after the first infusion

☐ 450mg IV 24 weeks after the first infusion and then 24 weeks thereafter

Maintenance Therapy:

☐ 450mg IV every 24 weeks

PROVIDER INFORMATION

Provider Name: Provider Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

SPECIAL INSTRUCTIONS

Provider Name **Provider Signature** **Date** ☐ **Check here if this is a stat order**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

PHONE: 516-340-4001 FAX: (516) 300-1825 EMAIL: healthinfusionservices@gmail.com