BRIUMVI
(ublituximab-xiiy)

FAX to + 1 208.963.3245 or
Email to intake@infusionspecialists.org
To ensure processing of your order, please complete all fields.

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:________________lbs or ____________kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- MRI Results
- History & Physical
- Neg Hep B Serology
- Patient Demographics
- Immunoglobulin Panel
- Most Recent Labs
- Medication List

PRIMARY DIAGNOSIS

☐ G35 Multiple Sclerosis
☐ Other: ____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: Acetaminophen 650 mg PO, Diphenhydramine 25 mg IV, and Methylprednisolone 100 mg IV (30 minutes prior to start of infusion)
☐ Provider Prescribed: ____

PRIMARY MEDICATION ORDER

☐ Induction: Briumvi 150 mg IV on day 1, followed by 450 mg on day 15, then 450 mg IV every 6 months thereafter.
☐ Maintenance: Briumvi 450 mg IV every 6 months
☐ Other: ____

First Dose: ☐Y ☐N ☑ Refill x12 months unless otherwise noted:______________________

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Infusion Specialists' protocol (See infusionspecialist.org for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Infusion Specialists' protocol (See infusionspecialist.org for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

______________________________________ ______________________
Provider Signature Date