LIFE SPECIALTY SOLUTIONS

BRIUMVI
(ublituximab-xiiy)

PATIENT INFORMATION

PATIENT NAME: ______ PHONE #: ______

ADDRESS: ______ CITY, STATE, ZIP: ______

DATE OF BIRTH: ______ EMAIL: ______

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

REQUIRED DOCUMENTATION

1. Insurance Card
2. History & Physical
3. Patient Demographics
4. Most Recent Labs
5. Medication List
6. MRI Results
7. Neg Hep B Serology
8. Immunoglobulin Panel

PRIMARY DIAGNOSIS

☐ G35.A Relapsing-remitting multiple sclerosis
☐ G35.B0 Primary progressive multiple sclerosis, unspecified
☐ G35.B1 Active primary progressive multiple sclerosis
☐ G35.B2 Non-active primary progressive multiple sclerosis
☐ G35.C0 Secondary Progressive multiple sclerosis, unspecified
☐ G35.C1 Active secondary progressive multiple sclerosis
☐ G35.C2 Non-active secondary progressive multiple sclerosis
☐ G35.D Multiple sclerosis, unspecified
☐ Other: ______

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: ______

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?: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted.

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
☐ Other Flush Orders: Please send other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
☐ Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: ______ PHONE: ______

OFFICE CONTACT: ______ FAX: ______

ADDRESS: ______ EMAIL: ______

CITY, STATE, ZIP: ______ NPI AND LICENSE: ______

✗ ______ ______

PROVIDER SIGNATURE DATE