

**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 Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See [lifespecialtysolutions.com](http://lifespecialtysolutions.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 Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See [lifespecialtysolutions.com](http://lifespecialtysolutions.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: \_\_\_\_\_

**X**

PROVIDER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_