

# BRIUMVI (UBLITUXIMAB-XIYY) ORDER FORM

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Mobile Number: \_\_\_\_\_ Patient Weight: \_\_\_\_\_ kg  
 Allergies: \_\_\_\_\_  
 Patient has known difficult venous access. Comments: \_\_\_\_\_  
 New Start Therapy |  Continuation of Therapy & Date of last dose (if applicable): \_\_\_\_\_

## DIAGNOSIS (Provider must specify)

Relapsing-remitting multiple sclerosis (RRMS), ICD 10: G35.A  
 Active secondary progressive multiple sclerosis (SPMS), ICD 10: G35.C1  
 Clinically isolated syndrome (CIS), ICD 10: G36.9

## PROVIDER INFORMATION

Provider Name (print name): \_\_\_\_\_ Provider NPI: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

### Prerequisites to treatment – ensure the following information is complete and attached with referral:

Demographics  Labs and tests supporting diagnosis  Office/progress notes

## PRE-MEDICATION

Recommendations per PI are selected, these will be given to patient unless otherwise specified.

Methylprednisolone (Solu-Medrol) 125mg IVP  Benadryl 25mg PO  Acetaminophen (Tylenol) 500mg PO  
 Famotidine 20mg IV  Cetirizine (Zyrtec) 10mg PO  
 Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

## MEDICATION

MEDICATION	DOSE
Briumvi	<input type="checkbox"/> First infusion: 150 mg IV; Second infusion: 450 mg IV two weeks after first infusion, then 450 mg IV 24 weeks after first infusion and every 24 weeks thereafter  <input type="checkbox"/> 450 mg IV every 24 weeks

## LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: \_\_\_\_\_

### FAX NUMBERS:

CT: 203.433.0621  
 FL: 904.877.9270

MA: 413.296.8482  
 MD: 240.224.8607  
 ME: 207.407.7272

NC: 919.984.8698  
 NH: 603.217.5371  
 NJ: 201.581.4521

NY: 631.250.6020  
 OH: 937.871.4594  
 PA: 610.273.5998

SC: 864.973.6279  
 VA: 703.202.0499