RESTORE HEALTH
INFUSION AND WELLNESS

BRIUMVI

Please include the following to expedite the order:
Patient Demographics, Insurance Information, Labs

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ **DOB**: _____ **Gender**: ☐ M ☐ F ☐ Other _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

PRESCRIBER

Name: _____ **DEA:** _____ **NPI:** _____ **State License:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

CLINICAL

Diagnosis: ☐ G35.A (Relapsing-Remitting Multiple Sclerosis) ☐ C37.9 (Clinically Isolated Syndrome)
☐ G35.C1 (Active Secondary Progressive Multiple Sclerosis ☐ Other: _____

Allergies: _____ **Weight:** _____ ☐ kg ☐ lbs **Height:** _____ ☐ cm ☐ in

Active Infection Present: ☐ Yes ☐ No **HBV:** ☐ Yes ☐ No If yes, treated: ☐ Yes ☐ No

CBC Completed: ☐ Yes ☐ No **CMP/LFTs Completed:** ☐ Yes ☐ No **Ig Panel Completed:** ☐ Yes ☐ No

TREATMENT

BRIUMVI (ublituximab-xiiy)

Route: Intravenous infusion

Dose: ☐ 150mg ☐ 450mg

Frequency:

☐ Induction: Day 1: 150mg IV over 4 hours
Day 15: 450mg IV over 1 hour

☐ Maintenance: 450mg IV every 24 weeks

☐ Observe patient for 1 hour after infusion
(optional after 2nd dose)

Quantity: _____ **Refills:** ____

Premedication Protocol:

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ Methylprednisolone: ☐ 40mg ☐ 125mg IV

☐ Other: _____

Sig: _____

■ *Center will use anaphylactic and hypersensitivity protocol established by Restore Health*

Special Instructions: _____

Provider Signature: _____ Date: _____