

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-xiiv)

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: _____

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