Briumvi Order Form
(ublituxima-xiiy)

medix infusion

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____

DOB: _____ Phone: _____ Sex: ☐ M ☐ F

DIAGNOSIS & CLINICAL INFORMATION

Primary ICD 10 Code (Required)

☐ G35 Multiple Sclerosis
☐ Relapsing/Remitting MS
☐ Other: _____

Patient status:
☐ New to therapy
☐ Continuing therapy
(date of last dose _____)

Weight: _____ ☐ lb ☐ kg **Height:** _____

Allergies: _____

PRESCRIPTION

Pre-Medications (Required): Must select one
☐ Diphenhydramine: 25mg PO 30-60 minutes prior to infusion OR
☐ Diphenhydramine: 25mg IVP (if neither is selected, Medix will select IVP as default option unless contraindicated)
☐ Methylprednisolone: 100 mg SIVP 30 minutes prior to infusion

Optional
☐ Acetaminophen: 500mg PO 30 minutes prior to infusion
☐ Other: _____

BRIUMVI (pegloticase)
Loading Dose:
☐ 150 mg IV followed by 450 mg IV 2 weeks later, then 450 mg IV every 24 weeks for one year
Maintenance Dose:
☐ 450 mg every 24 weeks for one year

Is the patient on any other disease modifying therapy? ☐ Yes ☐ No

Is yes, please note therapy and last dose: _____

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Other Orders: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- Signed and completed order
- Patient's demographic and insurance information
- Patient's medication list
- Supporting clinical notes that include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

Supporting labs/diagnostics:
- Quantitative serum immunoglobulin and negative Hepatitis B within 3 years to initiate therapy
- Live vaccination schedule
- Serum immunoglobulins

Medix Infusion will collect all necessary labs if not included in referral documents

PRESCRIBER INFORMATION

Prescriber Name: _____

Signature: _____

NPI #: _____ Date: _____

Supervising Physician (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____