



Briumvi® Order Form (ublituxima-xiyy)

FAX TO: 972.499.9210

Patient Information

Patient Name: _____ DOB: _____ Phone: _____ Sex: M F Gender: _____
Ht: _____ Wt: _____ lbs kg Primary Language: _____
Allergies: _____ Patient Preferred Location: _____

Diagnosis

Primary ICD 10 Code (Required)

G35 Multiple Sclerosis
Relapsing/Remitting MS

Other: _____

Other ICD 10 Code: _____
Description _____

Patient Status

New to therapy
Continuing therapy
(date of last dose _____)

Infusion Orders

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: _____

Lab Orders+

Requested Add'l Lab Orders:

Lab Frequency: _____ every _____ weeks

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Loading Dose:

150 mg IV followed by 450 mg IV 2 weeks later

Maintenance Dose:

450 mg IV every 24 weeks after the first infusion and every 24 weeks thereafter

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 Clinical Documentation

- 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

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

If yes, please note therapy and last dose:

Supporting labs/diagnostics:

- Negative HBsAg result w/in 3 years of therapy initiation.
- Annual HBV screening form completed while on therapy.
- Quantitative serum immunoglobulin screening (IgG and IgM)

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

Referring Provider Information

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

Contact Name: _____ Phone: _____ Fax: _____ Email: _____