Briumvi®

Provider Order Form Rev. 07/2023

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

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

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Multiple Sclerosis, G35

☐ Other: _____, ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE/DIRECTIONS/DURATION
Briumvi® (ublituximab-xiiy)	☐ **INITIAL** • First Dose - Infuse 150 MG IV over 4 hours x 1 dose • Second Dose (2 weeks after 1st dose) - Infuse 450 mg IV over 1 hour x 1 dose ☐ **MAINTENANCE** • Second Dose (Infuse 450 mg IV over 1 hour every 24 weeks x 1 year *Observe patient for 1 hour after completion of infusion.

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

- Methylprednisolone 100mg IVP 30 minutes prior to infusion

☐ Acetaminophen 650mg PO 30 minutes prior to infusion

☐ Diphenhydramine 25mg/50mg PO 30 minutes prior to infusion

☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time ☐ IgG, IgA and IgM q _____

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____

☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

LAB AND TEST RESULTS (required)

- Hepatitis B Screening (submit results to start therapy)

PRIOR FAILED THERAPIES

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____