

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

INFUSION ORDERS

Table with 2 columns: MEDICATION and DOSE/DIRECTIONS/DURATION. Row 1: Briumvi® (ublituximab-xiy) [] 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? If yes, Facility Name: _____
[] Yes [] No 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: _____ NPI: _____ TIN: _____ 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.

Clinical Information, select all that apply:

- [] The patient has an MRI of the brain and/or spinal cord consistent with diagnosis of MS.
[] Physician documentation clearly indicates diagnosis of relapsing MS, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.

For Anthem BCBS only:

Physician documentation supports the following:

- [] Patient can ambulate without aid or rest for ≥100 meters.
[] If initiating therapy, patient has experienced at least two relapses within the previous 2 years or one relapse within the previous year.

LAB AND TEST RESULTS (required)

- Provide copy of Hepatitis B Screening
• Provide copy of baseline Quantitative Serum Immunoglobulins
• Provide copy of recent MRI

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: _____