immersiv HEALTH

# BRIUMVI® ORDER FORM

**FAX TO: 855.694.4656**

## PATIENT INFORMATION

**PATIENT NAME:** _____ **PHONE:** _____

**DATE OF BIRTH:** _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

**ALLERGIES:** _____ **PREFERRED CLINIC:** _____

**REFERRAL STATUS:** ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

## DIAGNOSIS & CLINICAL DOCUMENTATION

☐ G35 Primary Progressive Multiple Sclerosis

☐ G35 Relapsing Remitting Multiple Sclerosis

☐ ICD-10 CODE: _____ DESCRIPTION: _____

## REQUIRED DOCUMENTATION

☐ Insurance Information

☐ List of Medications

☐ Tried & Failed Therapies

☐ Most Recent Physical & History

☐ Negative Hepatitis B

☐ Quantitative Serum IG screening

## MEDICATION ORDER

☐ **LOADING:** Briumvi® (ublituximab) 150 mg IV in 250 ml NS over 4 hours at week 0 followed by 450 mg IV in 250 ml NS over 60 minutes at week 2

☐ **MAINTENANCE:** Briumvi® (ublituximab) 450 mg IV in 250 ml NS over 60 minutes every 24 weeks

* Maintenance dosing scheduled 6 months from initial week 0 dosing

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

### PRE-MEDICATIONS

**REQUIRED**

| | | |
|---|---|---|
| ☑ Acetaminophen: 500 mg | ☑ PO | ☐ IV |
| ☑ Methylprednisolone: 125 mg | ☐ PO | ☑ IV |
| ☑ Diphenhydramine: 25 mg | ☐ PO | ☑ IV |

**OTHER:** _____ ☐ PO ☐ IV

Patient to be observed for 60 minutes following the first two infusions.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

## PRESCRIBER INFORMATION

**PROVIDER NAME:** _____ **NPI #:** _____

**EMAIL:** _____ **PHONE:** _____ **FAX:** _____

**ADDRESS (INCLUDE CITY, STATE, ZIP):** _____

**SUPERVISING PHYSICIAN:** (IF APPLICABLE) _____ **CONTACT NAME:** _____

**SIGNATURE:** (NO STAMPS) _____ _____ **DATE:** _____

SUBSTITUTION PERMITTED | DISPENSE AS WRITTEN