

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.A Relapsing-Remitting MS (RRMS)
- G35.B2 Non-Active Primary Progressive MS (PPMS)
- G35.B0 Primary Progressive MS (PPMS), unspecified
- G35.C1 Active Secondary Progressive MS (SPMS)
- G35.B1 Active Primary Progressive MS (PPMS)
- G35.D Multiple Sclerosis, unspecified
- 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. Administer Per Protocol.
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: _____ CONTACT NAME: _____
(IF APPLICABLE)

SIGNATURE: _____ DATE: _____
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN