Local Infusion

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# BRIUMVI (UBLITUXIMAB-XIIY) ORDER FORM

## PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ Patient has known difficult venous access. Comments:_____

❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

## DIAGNOSIS (Provider must specify)

❑ Relapsing-remitting multiple sclerosis (RRMS), ICD 10: G35.A
❑ Active secondary progressive multiple sclerosis (SPMS), ICD 10: G35.C1
❑ Clinically isolated syndrome (CIS), ICD 10: G36.9

## PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

**Prerequisites to treatment –** ensure the following information is complete and attached with referral:
❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

## PRE-MEDICATION

Recommendations per PI are selected, these will be given to patient unless otherwise specified.

☑ Methylprednisolone (Solu-Medrol) 125mg IVP

☑ Benadryl 25mg PO

☑ Famotidine 20mg IV

☑ Acetaminophen (Tylenol) 500mg PO

❑ Cetirizine (Zyrtec) 10mg PO

❑ Other: _____ Dose: _____ Route: _____

## MEDICATION

| MEDICATION | DOSE |
|---|---|
| Briumvi | ❑ First infusion: 150 mg IV; Second infusion: 450 mg IV two weeks after first infusion, then 450 mg IV 24 weeks after first infusion and every 24 weeks thereafter<br><br>❑ 450 mg IV every 24 weeks |

## LABS / SPECIAL INSTRUCTIONS