

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____
Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ Multiple Sclerosis ICD-10 Code: G35
 _____ Other: _____ ICD-10 Code: _____
 Allergies: _____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical notes and test supporting primary diagnosis
 - Include documentation of any previously trialed and/or failed therapies
- Recent lab results including:
 - Hepatitis B screenings
 - Quantitative serum immunoglobulin screenings (including IgM, IgA, IgG)
- Medication List

Patient	
Weight:	_____ lbs.
Height:	_____ in.

BRIUMVI™ (ublituximab-xiyy)

J Code: J2329

4. Drug Order:

Loading Dose

First Infusion: Administer 150 mg IV over 4 hours Doses authorized: 2 doses (4 * 150 mg vials)
 Second Infusion: Administer 450 mg IV over 1 hour, two weeks after the first infusion.

Maintenance Regimen (to start 24 weeks from the first infusion)

Administer 450 mg IV over 1 hour every 24 weeks Doses authorized: 2 doses (6 * 150 mg vials)

Pre-Medication Orders: Acetaminophen 650 mg PO, diphenhydramine 50 mg IV, and methylprednisolone 125 mg IV
 Administered 30 min prior to infusion *Adjust to patient's needs

Other orders: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
 Dispense as written Substitution permitted

Printed Physician's Name with Credentials: _____ NPI: _____

FAX ALL INFORMATION CENTRAL FAX 803.999.1754	INFUSION CENTER LOCATIONS BERKELEY CHARLESTON COLUMBIA GREENVILLE CENTRAL INTAKE PHONE 803.999.1760
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