INTRAMED Plus
infusion services

BRIUMVI®

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 ICD-10 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
  - o Include documentation of any previously trialed and/or failed therapies
- Recent lab results including:
  - o Hepatitis B screenings
  - o Quantitative serum immunoglobulin screenings (including IgM, IgA, IgG)
- Medication List

Patient
Weight: _____ lbs.
Height _____ in.

BRIUMVI ™ (ublituximab-xiiy) 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 our 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 INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**