

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: _____	Relapsing-remitting multiple sclerosis	ICD-10 Code: G35A
_____	Primary progressive multiple sclerosis, unspecified	ICD-10 Code: G35B0
_____	Active primary progressive multiple sclerosis	ICD-10 Code: G35B1
_____	Non-active primary progressive multiple sclerosis	ICD-10 Code: G35B2
_____	Secondary progressive multiple sclerosis, unspecified	ICD-10 Code: G35C0
_____	Active secondary progressive multiple sclerosis	ICD-10 Code: G35C1
_____	Non-active secondary progressive multiple sclerosis	ICD-10 Code: G35C2
_____	Multiple sclerosis, unspecified	ICD-10 Code: G35D
_____	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.
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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 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 FAX 803.999.1754

CENTRAL INTAKE PHONE
803.999.1750



Access Intramed Plus
 prescription
 order forms here.