



MEDICATION ORDERS

UBLITUXIMAB-XIIY (BRIUMVI)

PATIENT INFORMATION		
Date:	Patient Name:	DOB:
<input type="checkbox"/> NKDA Allergies:		
Patient Status:	<input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy - Last Treatment Date:	Next Due Date:

REFERRAL STATUS		
<input type="checkbox"/> New Referral	<input type="checkbox"/> Dose or Frequency Change	<input type="checkbox"/> Order Renewal

INFUSION OFFICE PREFERENCE (Optional)		
Preferred Location:	<input type="checkbox"/> Montgomery	<input type="checkbox"/> Prattville

DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Relapsing-Remitting Multiple Sclerosis	ICD-10 Code: G35
<input type="checkbox"/> Secondary Progressive Multiple Sclerosis	ICD-10 Code: G35
<input type="checkbox"/> Primary Progressive Multiple Sclerosis	ICD-10 Code: G35

REQUIRED DOCUMENTATION/TESTING	
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance info <input type="checkbox"/> Clinical/Progress notes supporting primary dx	<input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> Hepatitis B Test Results: HBsAg & Total HepB Core Antibody
Previous MS treatments and last date of therapy: 1) 2)	

PRE-MEDICATION ORDERS
<input checked="" type="checkbox"/> Acetaminophen (Tylenol) PO 1000mg <input checked="" type="checkbox"/> Diphenhydramine (Benadryl) 25mg IV <input checked="" type="checkbox"/> Methylprednisolone (Solu-Medrol) 125mg IV <input type="checkbox"/> Other:
Note: manufacturer recommended premedication regimen is Tylenol, Solu-Medrol and Benadryl

MEDICATION ORDERS	
Initial Dosing	<input type="checkbox"/> Briumvi 150 mg IV x 1 dose on day 1 then 450 mg IV on day 15 followed by maintenance in 6 months
Maintenance Dosing	<input type="checkbox"/> Briumvi 450 mg IV day 1 every 6 months
Other Dosing	<input type="checkbox"/> Briumvi _____ mg IV _____
Refills:	<input type="checkbox"/> None <input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> Other: _____
<ul style="list-style-type: none">New orders and progress notes required at least once yearly. A medication substitution may be required based on insurance payer policy due to preferred versus non-preferred medications or based on payer step therapy guidelines.Please note: if an infusion reaction occurs, the Montgomery Cancer Center provider will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.	

PROVIDER INFORMATION			
Office Contact Name:			
Prescribing Providers Name:		Provider NPI:	
Office Address:	City:	State:	Zip:
Office Phone Number:		Office Fax Number:	
Physician Signature:		Date:	

Contact us with questions at: Montgomery (334) 273-7000 or Prattville (334) 351-1000

Fax completed form and all documentation to Montgomery (334) 260-2011 or Prattville (334) 358-1207