MEDICATION ORDERS

UBLITUXIMAB-XIIY (**BRIUMVI**)

PATIENT INFORMATION		
Date:	Patient Name:	DOB:
❑ NKDA Allergies:		
Patient Status: ❑ New to Therapy ❑ Continuing Therapy - Last Treatment Date:		Next Due Date:

REFERRAL STATUS		
❑ New Referral	❑ Dose or Frequency Change	❑ Order Renewal

INFUSION OFFICE PREFERENCE (Optional)		
Preferred Location:	❑ Montgomery	❑ Prattville

DIAGNOSIS AND ICD 10 CODE	
❑ Relapsing-Remitting Multiple Sclerosis	ICD-10 Code: G35
❑ Secondary Progressive Multiple Sclerosis	ICD-10 Code: G35
❑ Primary Progressive Multiple Sclerosis	ICD-10 Code: G35

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

PRE-MEDICATION ORDERS
✓ Acetaminophen (Tylenol) PO 1000mg ✓ Diphenhydramine (Benadryl) 25mg IV ✓ Methylprednisolone (Solu-Medrol) 125mg IV ❑ Other:
Note: manufacturer recommended premedication regimen is Tylenol, Solu-Medrol and Benadryl

MEDICATION ORDERS	
Initial Dosing	❑ 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	❑ Briumvi 450 mg IV day 1 every 6 months
Other Dosing	❑ Briumvi _____ mg IV ___________
Refills: ❑ None ❑ x 6 months ❑ x 1 year ❑ Other: ___________	

- 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

All information contained in this form is strictly confidential and will become part of the patient's medical record.