***Patient Insurance & ID (front and back) are needed**

BRIUMVI (ublituximab-xiiy)

☐ New Prescription/Referral
☐ Prescription Refill

 # Of Refills:

Rx:

Patient Name:

Patient Weight: kg

DOB:

Briumvi:
(ublituximab-xiiy)

(*Pre-Medications Required)

☐ Initial Dose: 150mg IV, then 450mg IV 2 weeks later
☐ Maintenance Dose: 450 mg IV 24 weeks after the first infusion x 1 year
☐ Other: _____

Pre-Medication:

☐ Solumedrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Others:

☐ Tylenol _____mg PO
☐ 650mg ☐ 975mg

☐ Benadryl _____mg
☐ 25mg ☐ IV
☐ 50mg ☐ PO

ANA Kit Protocol:

☐ OK to use

Dx:

Diagnosis: Multiple Sclerosis **ICD-10:**

Type (required): ☐ Relapsing - Remitting ☐ Secondary - Progressive ☐ Clinically Isolated

Physician Signature **NPI #:** **DATE:(Valid for 1 year)**

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name: **Clinic:**

Phone: **Fax:** **Email:** **Other:**

Office Mailing Address:

Please include the following

☐ *Patient demographics ☐ *Insurance attached ☐ *Diagnosis(supporting) ☐ *History & Physical
☐ *Lab Results ☐ *Clinical progress notes ☐ *Medication list ☐ *Other Test Results
☐ *Quantitative Immunoglobulin ☐ *Hep B Surface Ag (within 12 months) ☐ *Hep B Core AB (within 12 months)

We can do patient teaching for IV/IM/SQ injections if needed. One time or multiple visits. If insurance allows we can also administer SQ/IM shot.