



Please fax completed form, insurance card, and clinical documentation to:
FAX: (334)284-3107

BRIUMVI ORDER

New Start Maintenance: Last Dose Given _____

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	

Allergies NKDA Allergies: _____

Height: _____ Weight: _____

Indication:

G35.1__ Relapsing Remitting Multiple Sclerosis

G35.3__ Secondary Progressive Multiple Sclerosis

G37.__ Clinically Isolated Syndrome

Other _____

DOSAGE ORDERS:

Induction: **150mg** IV on Day 1 then 450mg IV on Day 15

Maintenance: 450mg IV every 6 months

Other _____

PREMEDICATION ORDERS: *antihistamine and 100mg methylprednisolone are recommended in the PI*

Acetaminophen po: 1000mg 500mg 30 min prior to infusion.

Diphenhydramine: 25mg PO 50mg PO 25mg IVP 30 min prior to infusion.

Solu-Medrol: 62.5mg IVP 100mg IVP Other _____ 30 min prior to infusion.

Other _____

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive ALL the following:

- Face Sheet / Patient Demographics
- Insurance card(s) – copy of front & back
- Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes)
- Most Recent Labs (within last 4-8 weeks) – Required:
- CBC CMP TB Hep B Other: _____