BRIUMVI Infusion Referral Form

Fax Referral To:
877-438-9380

CONTINUUM Health

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ◯ M ◯ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ◯ N ◯ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Primary Diagnosis: _____ Multiple Sclerosis

_____ Other: _____

Please attach the following: 1. Clinical MD Notes,/History 2. Most Recent Labs 3. Copy of the patient's Insurance Card 4. Medications List 5. Immunoglobulin Panel 6. MRI Results 7. Neg Hep B Serology

Physician Information

Prescribing Physician: _____ Practice Name: _____

Practice Phone: _____ Practice Fax: _____

Email: _____ Office Contact: _____

Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: **BRIUMVI (ublituximab-xiiy)**

_____ # Refills (Recommend 5 refills)

☐ ***Initial Dose:*** Briumvi 150 mg IV on day 1, followed by 450 mg on day 15, then 450 mg IV every 24 weeks thereafter.

☐ ***Maintenance:*** Briumvi 450 mg IV every 24 weeks

Pre-Medication Orders:

☐ Per infusion clinic protocol: Acetaminophen 650 mg PO, Diphenhydramine 25 mg IV, and Methylprednisolone 100 mg IV (30 minutes prior to start of infusion)

☐ Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____

Physician's NPI# Physician's Address

_____ _____

Prescriber's Signature Date