Site of Care

☐ Home Infusion
☐ Infusion Center
☐ Doctor's Office

Fax Referral to (855) 644-3687 or Email: Referrals@sandshealth.com

BRIUMVI (UBLITUXIMAB-XIIY) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____

Allergies: _____

DIAGNOSIS ovider must specify)

☐ Multiple Sclerosis ICD10: _____
☐ Other: _____

Prior to treatment – ensure the following information is complete and attached with referral:

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Benadryl 25 mg PO ☐ Methylprednisolone (Solu-Medrol) ____mg IVP

Other: _____ Dose: _____ Route: _____

Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE / ROUTE / FREQUENCY
BRIUMVI	☐ First infusion: 150 mg IV; Second infusion: 450 mg IV two weeks after first infusion, then 450 mg IV 24 weeks after the first infusion and every 24 weeks thereafter ☐ 450 mg IV every 24 weeks

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

LABS/SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Provider Name: _____ Provider NPI: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Signature: _____ Date: _____

Order valid for 1 year from date of signature unless otherwise specified here: _____