



Please fax completed form, insurance card, and clinical documentation to:  
**FAX: 843-793-6181**

**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.A\_\_ Relapsing Remitting Multiple Sclerosis

G35.C1\_\_ Secondary Progressive Multiple Sclerosis

G36.9\_\_ Clinically Isolated Syndrome

Other

**DOSAGE ORDERS:**

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

Maintenance: 450mg IV every 24 weeks after 1st infusion

Other

**PREMEDICATION ORDERS:**

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

Diphenhydramine:  25mg PO  50mg PO  25mg IVP 30-60 min prior to infusion. -REQUIRED

Methylpredisolone:  62.5mg IVP  100mg IVP  Other \_\_\_\_\_ 30-60 min prior to infusion.-REQUIRED

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
  - Alkaline Phosphatase (ALP)
  - Bilirubin
  - Quantitative Serum Immunoglobulin
- Other: \_\_\_\_\_

**CAUTIONS: Observe patient for at least 1 hour after first 2 infusions**