# Briumvi™

Referring Physician Orders Rev. 3/2025

Please fax completed referral form & all required documents to 770-618-9617

CPS INFUSION

## PATIENT DEMOGRAPHICS

***Insurance Information: Please attach copy of insurance card* front and back *(required)***

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

## DIAGNOSIS*

**ICD-10 CODE *(required)*** ***Please complete 2nd and 3rd digits to complete ICD-10 for billing***

☐ G35.A Relapsing Remitting Multiple Sclerosis (RRMS)

☐ G35.C1 Active Secondary Progressive Multiple Sclerosis (SPMS)

☐ Other: _____, ICD-10 _____

## INFUSION ORDERS

**MEDICATION**

**Briumvi™** (ublituximab)

**DOSE**

☐ First Dose: 150mg

☐ Second and Subsequent 450mg

**DIRECTIONS/DURATION**

☐ First Dose: Infuse IV over 4 hours x 1 dose

☐ Second Dose: (2 weeks after 1st Dose): Infuse IV over 1 hour x 1 dose

☐ Subsequent Doses: Infuse IV over 1 hour every 6 months x 1 year

*Observe patient for 1 hour after completion of first two infusions.*

Is patient currently receiving therapy above from another facility? ☐ NO ☐ YES

If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

## OTHER ORDERS

**LAB ORDERS:** Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____ ☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

**PRE-MEDICATION ORDERS:**

☐ No premeds ordered at this time ☐ Diphenhydramine 25mg PO ☐ Other: _____

☐ Acetaminophen 650mg PO ☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IV

## REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

## REQUIRED CLINICAL DOCUMENTATION

***Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis***

**TEST RESULTS *(required)***

- Hepatitis B Screening for Ocrevus (submit results to start therapy)
- JC virus (JCV) antibody testing for Tysabri (submit results to start therapy and every 6 months to continue therapy)
  - Continuation labs to be done by: ☐ Infusion Center ☐ Referring Physician
- Meningococcal vaccination for Soliris (must be completed at least 2 weeks prior to starting therapy)

**DIAGNOSTIC TEST RESULTS** (please attach copy for all items checked)

**For ALS:**

☐ ALS Functional Rating Scale-revised (ALSFRS-r)

☐ Pulmonary function test

**For CIDP:**

☐ Electromyography (EMG) and Nerve conduction velocity (NCV) tests

☐ Lumbar puncture test

☐ Nerve biopsy report

☐ Neurological Rankin Scale Score

**For MMN:**

☐ Electromyography (EMG) and Nerve conduction velocity (NCV) tests

☐ anti-GM1 antibodies

☐ Lumbar puncture test

**For Myasthenia Gravis:**

☐ Acetylcholine receptor (AChR) antibodies

☐ Baseline MG-Activities of Daily Living (MG-ADL) Evaluation

**PRIOR FAILED THERAPIES** (including DMARDs, immunosuppressants, and biologics)

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____