

PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND– Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION

G35 MS (relapsing remitting) Other (Specify ICD-10 Code): _____

Lab Orders: _____ Frequency: _____

Has patient received/plans on receiving any live or live-attenuated vaccinations 4 weeks prior to starting Briumvi™ treatment? Yes No

Has Patient received/plans on receiving any non-live vaccinations 2 weeks prior to starting Briumvi™ treatment? Yes No

Has Quantitative Serum Immunoglobulin Screening been performed? Yes No (Serum Immunoglobulin levels: _____)

Has patient received an HBV Screening? Yes No (Results: Negative Positive)

BRIUMVI™ ORDERS

Prescription type: New start Restart Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose/Frequency	Refills
<input type="checkbox"/> Briumvi™ 150mg vial	<input type="checkbox"/> First Infusion: 150 mg (1 vial) <input type="checkbox"/> Second Infusion: 450 mg (3 vials) (2 weeks after initial dose) <input type="checkbox"/> Subsequent Infusion: 450 mg (3 vials) once every 24 weeks <input type="checkbox"/> Other: _____	Refill: _____

Pre- Medication	Route	Dose
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> PO	<input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg
<input type="checkbox"/> Methylprednisolone (Solu-Medrol)	<input type="checkbox"/> IV	<input type="checkbox"/> 60mg <input type="checkbox"/> 100 mg <input type="checkbox"/> _____ mg
<input type="checkbox"/> Diphenhydramine (Benadryl)	<input type="checkbox"/> IV <input type="checkbox"/> PO	<input type="checkbox"/> 25mg <input type="checkbox"/> 50mg
Other: _____	_____	_____

ANAPHYLACTIC REACTION (AR):

EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary

EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg): may repeat in 3-5 mins x 1 if necessary

Diphenhydramine 50mg (1mL) - Give 50 mg slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary

Hydrocortisone 100mg - Give 100 mg IVP -or- IM if no IV access

Sodium Chloride 0.9% 500 mL infuse IV at a rate of 30 mL/hr

Other: _____

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BRIUMVI™

Please Fax Completed Form To: **800-783-9146**

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

SIGNATURE

X _____

Date: _____

Prescriber Signature

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