

PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION	
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: ☐ M ☐ F Weight: _____ (lbs) Ht: _____ Allergies: _____		Prescriber Name: _____ State License: _____ NPI #: _____ Tax ID: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____	
INSURANCE INFORMATION – AND– Send a copy of the patient's prescription/insurance cards (front & back)			
Primary Insurance: _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____		Secondary Insurance (If Applicable): _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____	
CLINICAL INFORMATION			
☐ G35.A Relapsing-remitting multiple sclerosis ☐ G35.B0 Primary progressive multiple sclerosis, unspecified ☐ G35.B1 Active primary progressive multiple sclerosis ☐ G35.B2 Non-active primary progressive multiple sclerosis ☐ G35.C0 Secondary progressive multiple sclerosis, unspecified ☐ G35.C1 Active secondary progressive multiple sclerosis ☐ G35.C2 Non-active secondary progressive multiple sclerosis ☐ G35.D Multiple sclerosis, unspecified ☐ 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	
☐ Briumvi™ 150mg vial	☐ First Infusion: 150 mg (1 vial) ☐ Second Infusion: 450 mg (3 vials) (2 weeks after initial dose) ☐ Subsequent Infusion: 450 mg (3 vials) once every 24 weeks ☐ Other: _____	Refill: _____	
Pre- Medication	Route	Dose	
☐ Acetaminophen	☐ PO	☐ 500mg ☐ 650mg ☐ 1000mg	
☐ Methylprednisolone (Solu-Medrol)	☐ IV	☐ 60mg ☐ 100 mg ☐ _____mg	
☐ Diphenhydramine (Benadryl)	☐ IV ☐ PO	☐ 25mg ☐ 50mg	
Other: _____	_____	_____	
ANAPHYLACTIC REACTION (AR):			

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- ☐ 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: _____

SIGNATURE

X _____

Prescriber Signature

Date: _____

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