BioTek reMEDys®

BRIUMVI™

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

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

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____ SS#: _____

Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____

Allergies: _____

PRESCRIBER INFORMATION

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):

BRIUMVI™

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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_____ Date: _____

Prescriber Signature