

Briumvi (ublituximab-xiyy)

Provider Order Form rev. 1/2/2025



PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB: _____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

☐ NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

☐ G35 Multiple Sclerosis

☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication), signed prescription order and recent visit notes.

Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications (Required)

☐ Diphenhydramine: 25 mg PO 30-60 minutes prior to infusion

☐ Diphenhydramine (Benadryl) ☐ 25mg IVP

☐ Methylprednisolone (Solu-Medrol) 100 mg SIVP

☐ Other: _____ Dose: _____ Route: _____

Lab Orders

Required: MRI Results, Neg Hep B Serology, Immunoglobulin Panel

☐ Other: _____

Briumvi Medication (Select one):

Loading Dose:

☐ 150 mg IV followed by 450 mg IV 2 weeks later, then 450 mg IV every 24 weeks for one year

Maintenance Dose:

☐ 459 mg every 24 weeks for one year

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

Special Instructions: _____

☐ Refills: ☐ zero ☐ for 12 months ☐ _____ (Prescription valid for one year, unless otherwise indicated)

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print)

Provider Signature

Date

E: Referrals@americaninfusioncare.com
Americaninfusioncare.com

Greater Houston Area F: 832.510.7824 P: 832.800.3213
McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454