

PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____
 Address: _____ Phone: _____ Allergies: _____
 City, State, Zip: _____ Email: _____

REFERRAL STATUS

New Referral Dose or Frequency Change Order Renewal
 Is this the first dose? Yes No, date of last infusion: _____ Line type: PIV PICC Port Other

DIAGNOSIS AND ICD-10 CODE

- | | |
|---|---|
| <input type="checkbox"/> Relapsing-remitting multiple sclerosis (G35.A) | <input type="checkbox"/> Secondary progressive multiple sclerosis, unspecified (G35.C0) |
| <input type="checkbox"/> Primary progressive multiple sclerosis, unspecified (G35.B0) | <input type="checkbox"/> Secondary progressive multiple sclerosis, active (G35.C1) |
| <input type="checkbox"/> Primary progressive multiple sclerosis, active (G35.B1) | <input type="checkbox"/> Secondary progressive multiple sclerosis, non-active (G35.C2) |
| <input type="checkbox"/> Primary progressive multiple sclerosis, non-active (G35.B2) | <input type="checkbox"/> Multiple sclerosis, unspecified (G35.D) |

REQUIRED DOCUMENTATION

- | | |
|---|---|
| <input type="checkbox"/> This signed order form by the provider | <input type="checkbox"/> Labs and Tests supporting primary diagnosis |
| <input type="checkbox"/> Patient demographics AND insurance information | <input type="checkbox"/> Hepatitis B Test Results: HBsAg & Total HepB Core Antibody |
| <input type="checkbox"/> H&P Clinical/Progress notes supporting primary diagnosis | <input type="checkbox"/> TB Test Results |
| <input type="checkbox"/> Quantitative serum immunoglobulin | |
- Current MS treatment and end of current therapy date: _____

PREMEDICATION ORDERS

- Acetaminophen PO 500mg 650mg 1000mg
 Diphenhydramine PO 25mg 50mg
 Methylprednisolone IV 40mg 100mg _____mg
 Other: _____

MEDICATION ORDERS

Initial Dosing	<input type="checkbox"/> Briumvi 150mg IV x 1 dose then 450mg IV 2 weeks after first infusion
Maintenance Dosing	<input type="checkbox"/> Briumvi 450mg IV every 24 weeks (to begin 24 weeks from first infusion)

Refills*: X 6 months X 1 Year Other: _____
 ** Infusions will be titrated to maximum recommended rate as suggested in prescribing information.

- RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration
 RN to flush and lock VAD/CVAD per company protocol

Other: _____

Observe patient for 60 minute post infusion of first two infusions. If no infusion reaction or hypersensitivity has been observed, patient is not required to stay for subsequent infusions.

EMERGENCY MEDICATIONS

Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):

- Diphenhydramine 25mg-50mg PO
- Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
- Acetaminophen 325mg-650mg PO
- Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
- Epinephrine 0.3mg IM/SQ, may repeat x1
- Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive
- Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

Pediatrics (weight <40kg): (may adjust with weight changes)

- Diphenhydramine 25mg PO
- Diphenhydramine 25mg slow IV push over 2-5 mins
- Acetaminophen 325mg PO
- Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
- Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
- Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____
 Office Phone: _____ Office Fax: _____
 Prescriber Signature: _____ Date: _____