



Nevada Infusion

Reno Location - 5401 Longley Lane, Suite 34, Reno, NV 89511

Carson Location - 180 E. Winnie Lane, Carson City, NV, 89706

PH: 775-453-0667 | Fax: 775-470-8478

Briumvi Order Form

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

DIAGNOSIS:

- | | |
|--|--|
| <input type="checkbox"/> Relapsing-Remitting MS ICD-10: G35A | <input type="checkbox"/> Non-Active Secondary Progressive MS ICD-10: G35C2 |
| <input type="checkbox"/> Primary-Progressive MS NOS ICD-10: G35B0 | <input type="checkbox"/> Secondary-Progressive MS NOS ICD-10: G35C0 |
| <input type="checkbox"/> Active Primary Progressive MS ICD-10: G35B1 | <input type="checkbox"/> Multiple Sclerosis, NOS ICD-10: G35D |
| <input type="checkbox"/> Active Secondary Progressive MS ICD-10: G35C1 | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Non-Active Primary Progressive MS ICD-10: G35B2 | ICD-10: _____ |

ORDER FOR BRIUMVI (UBLITUXIMAB-XIY):

- ☐ **Initial Dose:** First Infusion 150 mg IV as a single dose, followed by 450 mg IV 2 weeks later, and then 450 mg IV every 24 weeks starting 24 weeks after the initial dose x 1 year
- ☐ **Maintenance Dose:** 450 mg IV every 24 weeks starting 24 weeks after the initial dose x 1 year

****Patient will be monitored for at least 1 hour following the completion of the first 2 infusions****

PRE-MEDICATIONS:

- ☒ Acetaminophen 650mg PO
- ☒ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
- ☒ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☐ Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☒ Nevada Infusion Hypersensitivity Reaction Order Set
- ☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line

FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml

NURSING: Per Nevada Infusion

LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI: _____
Physician Signature: _____ Date: _____
Point of Contact: _____ Phone: _____ Email: _____



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Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

- ☐ Signed provider orders (page 1)
- ☐ Patient demographic and insurance information
- ☐ Patient's current medication list
- ☐ Supporting recent clinical notes and H&P (to support primary diagnosis)
 - ☐ Expanded Disability Status Scale (EDSS) Score: _____
- ☐ Include labs and or tests results to support diagnosis
 - ☐ MRI
- ☐ If applicable - Last Known biologic therapy: _____ and last date received: _____
_____. If patient is switching to biologic therapies, please perform a wash out period of _____ weeks prior to starting Briumvi.
- ☐ Hepatitis B Screenibg tests completed. This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) - attach results
- ☐ Serum Immunoglobulins (recommended)
- ☐ Other medical necessity documentation (please include): _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

****Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. ****