Intravene – BRIUMVI Order Form (rev 8/23)

Please fax this form along with a copy of insurance cards and clinical documentation to: (434) 455-5531 or call (434) 947-3900 ext. 3001

PATIENT INFORMATION

Name _____
Address _____
City _____
State _____ Zip Code _____
Home Phone # _____
Work Phone # _____
DOB _____SSN _____
Height _____ Weight _____lbs
Drug Allergies_____
□ NKDA Sex: □ Male or □ Female

REFERRING PHYSICIAN INFORMATION

Physician Name _____
Physician Address_____
_____
Physician Phone(_____)_____
Physician Fax(____)_____
NPI#_____DEA#_____
State License#_____

****Please fax copies of insurance cards** and this form to 434-455-5531**

DIAGNOSIS: (ICD-10 required)

- ☐ G35 Multiple Sclerosis
- ☐ _____

PRE TREATMENT SCREENING:

Hepatitis B Screening: Date/ Results:_____
Hepatitis C Screening: Date/Results:_____
Quantitative Serum Immunoglobulin Screening: Date: _____ Attach results

STANDARD ORDERS:

Infuse Briumvi 150mg in Normal Saline 250ml. Then Briumvi 450mg in Normal Saline 250mg 2 weeks after 1st dose. Then Briumvi 450mg in Normal Saline every 24 weeks starting after the first dose. Infuse by manufacturer titration protocol. Upon completion of Briumvi infusion, infuse Normal Saline 20- 100ml to clear line.

Premedications:
Methylprednisolone 100mg IV 30 minutes prior to infusion.
Diphenhydramine 25mg-50mg PO or IV 30 min. prior to infusion.
Acetaminophen 650mg PO 30 minutes prior to infusion.

LABS: _____

Anaphylactic meds and Vital Sign Monitoring per Intravene Protocol

Signature, prescribing MD _____Date _____