REVITALIZE
INFUSION CENTER

Briumvi®

Infusion Order Form

Patient Information:

_____	_____	_____
Patient Name	**DOB**	**Phone Number**

Medical Information:

Primary Diagnosis (please complete to indicate the correct diagnosis):

☐ Multiple Sclerosis_____ ICD-10 Code: G35.____

☐ Other_____ ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Medication List
- Required Information:
  - Previously trialed and failed therapies
  - Recent labs including:
    - Hepatitis B Screening Results
    - Quantitative Serum Immunoglobulin Screenings

Height: _____

Weight: _____

Briumvi® (ublituximab) Orders:

☐ Loading Dose

First Infusion : Administer 150 mg intravenously over four (4) hours

Second Infusion: Administer 450 mg intravenously over 1 hour two weeks after the first infusion

☐ Maintenance Regimen

Administer 450 mg intravenously over one (1) hour every 24 weeks (24 weeks after the first infusion) for two total doses (Requires 6 * 150 mg vials)

Pre-Medication Orders: Acetaminophen 650 mg PO, Diphenhydramine 50 mg IV and methylprednisolone 125 mg IV administered 30 minutes prior to the Briumvi infusion (Adjust PRN)

Lab Orders:_____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____	_____
Prescriber's Signature	**Date**
_____	_____
Prescriber's Printed Name	**Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize | Revitalize Locations | InfusionPlus