O·S·M·S
ORTHOPEDIC & SPORTS MEDICINE SPECIALISTS

RHEUMATOLOGY & INFUSION THERAPY CLINIC
Green Bay • Fox Valley • Marinette • Oshkosh
Phone: 920-430-8113 • Infusion Fax: 920-965-6389
osmsgb.com

Briumvi (Ublituximab-xiiy)

Referral Status: New Referral Dose or Frequency Change Order Renewal

Infusion Office Preference: Green Bay Neenah Marinette

PATIENT INFORMATION		
Date: Patient Name:		DOB:
☐ NKDA Allergies:		Weight:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date:		Next Due Date:
PROVIDER INFORMATION		
Office Contact Name:	Office Email:	
Prescribing Providers Name:	Provider NPI:	
Office Address:	City: State:	Zip:
Office Phone Number:	Office Fax Number:	

DIAGNOSIS AND ICD 10 CODE		**REQUIRED DOCUMENTATION**
☐ Relapsing-Remitting Multiple Sclerosis	ICD 10 Code: G35	☐ This signed order form by the provider
☐ Secondary Progressive Multiple Sclerosis	ICD 10 Code: G35	☐ Patient demographics AND insurance information (copy of cards)
☐ Primary Progressive Multiple Sclerosis	ICD 10 Code: G35	☐ Clinical/Progress notes
☐ Other: _____	ICD 10 Code: _____	☐ Lab and Tests supporting primary diagnosis
		☐ Hepatitis B Test Results: HBsAg, Total HepB Core Antibody
		☐ Hepatitis C Test Results
		☐ TB Test Results
		☐ Immunoglobulin Lab Results
		☐ Child Bearing Status

List Tried & Failed Therapies, including duration of treatment:

1.
2.
3.

PREMEDICATION ORDERS

☐ Acetaminophen (Tylenol) PO ☐ 500mg ☐ 1000mg
☐ Diphenhydramine (Benadryl) **PO / IV** ☐ 25mg ☐ 50mg (if route is not circled PO will be administered)
☐ Methylprednisolone (Solu-Medrol) IV ☐ 125mg ☐ 62.5mg
☐ Fexofenadine (Allegra) PO ☐ 180mg

Note: manufacturer recommended premedication regimen is Tylenol, Solu-Medrol and Benadryl.

MEDICATION ORDERS (order will expire in 1 year unless otherwise specified)

Initial Dosing	☐ Briumvi 150 mg IV x 1 dose then 450 mg IV at week 2 (observe for one hour post infusion)
Maintenance Dosing	☐ Briumvi 450 mg IV every 24 weeks (to begin 24 weeks from first infusion) *Post-infusion monitoring of subsequent infusions at the physicians discretion. Pt will be released after infusion unless observation time is requested by ordering MD.
Other Dosing	☐ Briumvi _____ mg IV _____
Refills	_ None _ X6 months _ X1 year _ Other: _____

**Please note: If an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion, or discontinuing the medication.*

LAB ORDERS

☐ Urine pregnancy test prior to each infusion **recommended for women of child bearing age**

Provider Name (Print) **Provider Signature:** **Date:**

Fax Referral to 920-965-6389

All information contained in this order form is strictly confidential and will become a part of the patient's medical record.