InfuCare Rx®

Briumvi™ Enrollment Form

Fax Referral To: 877-828-3941
Phone: 877-828-3940

✂ Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: ☐ Patient ☐ MD Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: _____
Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA #: _____ NPI #: _____
Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
Secondary Insurance: _____ ID: _____ Group: _____
Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS/CLINICAL INFORMATION

☐ G35 Multiple Sclerosis
☐ Other: _____

Hepatitis B Virus Screening: Date: _____
☐ Negative ☐ Positive
Quanitative Serum IG Level: _____ Date: _____
(attach clinicals for both)

Number of Relapses the past year: _____
Date of Diagnosis: _____
Date of last MRI: _____ MRI Changes: ☐ Yes ☐ No

Therapy: ☐ New ☐ Reauthorization ☐ Restart
☐ Buy & Bill ☐ Home
Prior Treatments Tried & Failed: _____
_____
Treatment Response: _____ Treatment Dates: _____
Patient Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in
Allergies: _____
Lab Data: _____
Concomitant Medications: _____
Comorbidities: _____

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Quantity/Refills:
Briumvi™ (ublituximab-xiiy) Initial Dose (two infusions)	☐ Day 1: 150mg in 250mL 0.9% NaCl IV over 4 hours As tolerated, start at 10mL/hr x 30 min, 20mL/hr x 30 min, 35mL/hr x 1hr then 100mL/hr for remaining 2 hours	Dispense: 150mg (1 vial)
	☐ Day 15: 450mg in 250mL 0.9% NaCl IV over 1 hour As tolerated, start at 100mL/hr x 30 min then 400mL/hr for the remaining 30 mins	Dispense: 450mg (3 vials)
*** Monitor for infusion reactions during infusion and observe for at least 1 hour after completion of the first two infusions**		
Briumvi™ (ublituximab-xiiy) Subsequent doses (one infusion)	☐ Every 24 weeks starting from Day 1: 450mg/250mL IV over 1 hour. As tolerated, start at 100mL/hr x 30 min then 400mL/hr for remaining 30 mins	Dispense: 450mg (3 vials) with 1 refill

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol
☐ NaCl 0.9% 5mL
☐ NaCl 0.9% 10mL
☐ Heparin 10 units per mL
☐ Heparin 100 units per mL
☐ 250mL 0.9% NaCl for hydration
☐ Other: _____

Premedications & Other Medications
☐ Infusion supplies as per protocol
☐ Anaphylaxis Kit orders as per protocol
Acetaminophen (Tylenol) PO 30-60 mins prior to infusion ☐ 325mg ☐ 500mg ☐ 650mg ☐ 1000mg
Methylprednisolone (Solu-Medrol) IVP 30 mins prior to infusion ☐ 100mg
Diphenhydramine (Benadryl) PO 30-60 mins prior to infusion ☐ 25mg ☐ 50mg

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Signature: _____ **Date:** _____

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