InfuCare Rx®

Briumvi® Enrollment Form

Fax Referral To: 877-828-3941
Phone: 877-828-3940
referrals@infucarerx.com
www.infucarerx.health

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:

Primary Diagnosis:

☐ G35.A Relapsing-remitting multiple sclerosis
☐ G35.B0 Primary progressive multiple sclerosis, unspecified
☐ G35.B1 Active primary progressive multiple sclerosis
☐ G35.B2 Non-active primary progressive multiple sclerosis
☐ G35.C0 Secondary progressive multiple sclerosis, unspecified
☐ G35.C1 Active secondary progressive multiple sclerosis
☐ G35.C2 Non-active secondary progressive multiple sclerosis
☐ G35.D Multiple sclerosis, unspecified
☐ Other ICD-10: _____

Hepatitis B Virus Screening: Date: _____
☐ Negative ☐ Positive

Quantitative 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

DIAGNOSIS/CLINICAL INFORMATION

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:** _____

The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intended recipient, please notify us immediately by faxing back to the originator.

Revised 11 November 2026