BRIUMVI™ (ublituximab-xiiy) Order/Referral Form

GAMMA THERAPEUTIC CENTER
Center for Neurological Disorders

Phone: (414) 460-3195
Fax: (414) 763-0063
www.gtinfusions.com

Patient Information	
Patient Name:	Patient DOB:

Referral Status

☐ New Referral ☐ Restart/Continuation ☐ Medication/Order Change ☐ D/C Infusions

Diagnosis and ICD 10 Code	
☐ Relapsing-remitting form of Multiple Sclerosis (MS)	ICD 10 Code: G35
☐ Clinically isolated form of Multiple Sclerosis (MS)	ICD 10 Code: G35
☐ Active secondary progressive disease form of Multiple Sclerosis (MS)	ICD 10 Code: G35
☐ Other Diagnosis:	ICD 10 Code:

Supporting Documentation	
☐ Patient demographics	☐ Clinical/Progress notes supporting primary diagnosis
☐ Copy of patient insurance card(s) – front & back	☐ Labs and tests including baseline liver function test
☐ Tried and Failed therapies	☐ Current Medication List

Medication Orders

☐ Initial/Reloading
- Dose 1: BRIUMVI™ 150mg in 250ml 0.9% NS over four hours
- Dose 2: BRIUMVI™ 450mg in 250ml 0.9% NS over one hour two weeks later. After induction, continue with the maintenance dosing and schedule below

☐ Maintenance Dose: BRIUMVI™ 450mg in 250ml 0.9%NS over one hour every 24 weeks.

*Each infusion flush with 0.9% sodium chloride at the completion of the infusion

Premedication

☐ Acetaminophen (PO): ☐ 500mg, ☐ 650mg, ☐ 1,000mg **OR** Ibuprofen (PO): ☐ 200mg, ☐ 400mg, ☐ 600mg
☐ Loratadine 10mg (PO) **OR** ☐ Diphenhydramine (PO): ☐ 25mg, ☐ 50mg
☐ Famotidine 20mg (PO) prior to methylprednisolone
☐ Methylprednisolone IV: ☐ 125mg, ☐ 250mg, ☐ 500mg, ☐ 1,000 mg, ☐ Other: _____ mg
☐ Hydrocortisone Sodium Succinate (Solu Cortef) 100 mg IVP
☐ Other (medication, dose, route, and frequency): _____

Labs

☐ CMP – frequency: _____ ☐ BMP – frequency: _____ ☐ HBV – frequency: _____ ☐ HIV – frequency: _____
☐ CBC w/o diff - frequency: _____ ☐ CBC w/diff - frequency: _____ ☐ CBC w/man diff - frequency: _____
☐ Serum Quantitative Immunoglobulins – frequency: _____
☐ Stratify™ JCV Antibody (with Index) with Reflex to Inhibition Assay – frequency: _____
☐ Urine pregnancy test prior to each infusion
☐ Other labs (e.g. thyroid, Blood Glucose) and frequency: _____

Notes (Additional Info)

Adverse and anaphylactic reactions and post infusion will be treated per Gamma Therapeutic Center protocol.

Prescriber Information

Prescriber Name:		NPI #:
Office Contact:	Office Phone:	Office Fax:
Prescriber Signature:		Date: (Order valid for one year)

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Gamma Therapeutic Center and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.

We will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.