

## Patient Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Email: \_\_\_\_\_ Weight: \_\_\_\_\_ ☐ lbs ☐ kgs  
Allergies: ☐ NKDA ☐ \_\_\_\_\_

**Required Documentation** Insurance Card | History & Physical | Patient Demographics | Most Recent Labs | Medication List  
MRI Results | Negative Hep B Serology | Immunoglobulin Panel

## Primary Diagnosis

☐ G35 Multiple Sclerosis  
☐ Other: \_\_\_\_\_

## Order Information

### Lab Orders (Include frequency)

Please list any labs to be drawn by the infusion clinic: \_\_\_\_\_

### Pre-Medications

☒ Per infusion clinic protocol: Acetaminophen 650 mg PO, Diphenhydramine 25 mg IV, and Methylprednisolone 100 mg IV 30 minutes prior to start of infusion  
☐ Provider Prescribed: \_\_\_\_\_

### Primary Medication Order

☐ Induction: Briumvi 150mg IV on Day 1, followed by 450mg 2 weeks later, then 450mg IV every 24 weeks after initial dose  
☐ Maintenance: Briumvi 450mg IV every 24 weeks  
☐ Other: \_\_\_\_\_  
First Dose: ☐ Yes ☐ No ☒ Refill x12 months unless otherwise noted: \_\_\_\_\_

### Line Use/Care Orders

☒ Start PIV/ACCESS CVC ☒ Flush device per BluHaven Health's protocol (see BluHaven.com for policy)  
☐ Other Flush Orders: Please fax other line care orders if checking this box.

### Adverse Reaction & Anaphylaxis Orders

☒ Administer acute infusion reaction and anaphylaxis medications per BluHaven Health's protocol (see BluHaven.com for policy)  
☐ Other: Please fax other reaction orders if checking this box.

## Provider Information

Name: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Email: \_\_\_\_\_ NPI: \_\_\_\_\_

I authorize BluHaven Health and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this order and any future related orders for the patient listed above.

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date