SPRINGSIDE INFUSION

# Briumvi

## Patient information

**Patient name** _____ **DOB** _____

**Mobile number** _____ **Weight** _____ ☐ kgs ☐ lbs

**Diagnosis**
☐ Relapsing-remitting multiple sclerosis, ICD 10: g35.a
☐ Active secondary progressive multiple sclerosis, ICD 10: g35.c1
☐ Clinically isolated syndrome (cis), ICD 10: g36.9
☐ Other _____

**Allergies** ☐ NKDA ☐ _____

## Medication instructions

**Pre-medications**
☐ N/A
☐ Provider prescribed: _____

**Medication order**

Dose
☐ First infusion: 150 mg IV; second infusion: 450 mt IV two weeks after first infusion; then 450 mg IV 24 weeks after first infusion; then every 24 weeks thereafter
☐ Option 450 mg IV every 24 weeks
☐ Other _____

Frequency
N/A
☐ Other _____

**Medication route**
☐ IV
☐ Other _____

**Lab order** (Include frequency)
Please list any labs to be drawn by the infusion clinic:
☐ N/A
☐ _____

**Prerequisites**
Please include the following with your fax submission: Labs and tests supporting diagnosis | Office / progress notes | Demographics | Baseline liver function tests (LFTs) (alt, ast, bilirubin, alkaline phosphatase) within 6 months | Negative Hep B test results

**Please send to** ☐ Columbia, MD ☐ Silver Spring, MD ☐ Bowie, MD ☐ Frederick, MD

## Referring provider information

**Referring provider name** _____ **NPI** _____

**Practice name** _____

**Point of contact** Name _____ Email _____ Phone _____

**Provider signature** _____ Date _____