BRIUMVI (UBLITUXIMAB) INFUSION ORDERS

P: 331-236-0610 | **F:** 331-314-8989

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 331-314-8989

Name:		DOB:		Gender: □ Female □ Male	
Address:		City:	State:	ZIP:	
Phone:	Email:	Height:	□ inches □ cm	Weight:	□lbs. □ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: □ New to Therapy □ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:	
Office Contact:			Email:	
Address:		City:	State:	ZIP:
NPI #:	DEA#:		Tax ID:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refills
Briumvi (ublituximab)	□Initial Dosing: First infusion: 150mg IV; Second infusion: 450mg IV administered 2 weeks after first infusion; Subsequent: 450mg IV at 24 weeks after the 1st infusion and q 24 weeks thereafter □ Maintenance Dosing: 450mg IV every 24 weeks □ Other dosing: _____	□ x 1 year □ _____

Protocol Pre-medication Orders: Solu-Medrol 100mg IV and diphenhydramine 25mg PO or IV 30 minutes before infusion *(if no contraindications)*

Additional Pre-medication Orders: _____

Other orders: _____

Lab orders: _____ Lab Frequency: _____

Required labs to be drawn by: □ LIVbetter □ Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. □ Dispense as written

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing *LIVbetter Infusions.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Prescriber Signature: X **Date:**

COMPREHENSIVE SUPPORT FOR BRIUMVI (UBLITUXIMAB) THERAPY

PATIENT INFORMATION

Name: DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

□ Include signed and completed order (MD/prescriber to complete page 1)

□ Include patient demographic information and insurance information

□ Include patient's medication list

□ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to therapy

  □ Expanded Disability Status Scale (EDSS) score: _____

□ Include labs and/or test results to support diagnosis

  □ MRI

□ If applicable - Last known biological therapy: _____ and last date received: _____. If patient is switching biologic therapies, please perform a wash-out period of _____ weeks prior to starting ublituximab.

□Other medical necessity: _____

REQUIRED PRE-SCREENING

□Hepatitis B screening test completed. This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) - attach results

□Positive □ Negative

□Liver function tests including bilirubin

□Serum Immunoglobulins (recommended)

*If Hepatitis B results are positive - please provide documentation of treatment or medical clearance