PARAGON HEALTHCARE

A Carelon Company

BRIUMVI (UBLITUXIMAB) INFUSION ORDERS

P: 877.365.5566 | **F:** 855.889.2946

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Diagnosis/ICD-10:

☐ Relapsing-remitting MS (G35.A)

☐ Primary progressive MS, unspecified (G35.B0)

☐ Primary progressive MS, active (G35.B1)

☐ Primary progressive MS, non-active (G35.B2)

☐ Secondary progressive MS, unspecified (G35.C0)

☐ Secondary progressive MS, active (G35.C1)

☐ Secondary progressive MS, non-active (G35.C2)

☐ MS, unspecified (G35.D)

Patient Weight: _____ lbs. (required) Allergies: _____

THERAPY ORDER

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 x1 year

☐ Maintenance Dosing: 450mg IV every 24 weeks x 1 year

☐ Other dosing: _____

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: _____

Lab Orders: _____ **Lab Frequency:** _____

Required labs to be drawn by: ☐ Paragon ☐ Referring Provider

Other orders: _____

Home IV Biologic Ana-kit Orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50mg orally OR IV (adult)
- NS 0.9% 1000mL IV bolus PRN (adult)
- Refer to physician order or institutional protocol for pediatric dosing

Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* 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.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Paragon selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

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COMPREHENSIVE SUPPORT FOR BRIUMVI (UBLITUXIMAB) THERAPY

PATIENT INFORMATION:

Patient 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

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance