



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

Name:		DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:		City:	State:	ZIP:
Phone:	Email:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg

Allergies: _____

Diagnosis Code ICD-10 (required):	Diagnosis Description:
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> 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)	<input type="checkbox"/> Initial Dosing: <ul style="list-style-type: none"> 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 <input type="checkbox"/> Maintenance Dosing: 450mg IV every 24 weeks <input type="checkbox"/> Other dosing: _____	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____

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: Paragon Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwritten "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 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.

Prescriber Signature: X	Date:
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PATIENT INFORMATION

Name:

DOB:

REQUIRED DOCUMENTATION FOR REFERRAL CROSSING & 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