Briumvi Infusion Order

LivWell INFUSIONS

Fax 888 511-7654 *Phone 888 864-7341*

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis: ◯ G35 Multiple Sclerosis

- ☐ Relapsing-Remitting MS
- ☐ Secondary Progressive MS
- ☐ Clinically Isolated

Patients weight: _____

Lab Date: _____

Allergies: _____

ICD 10 : _____

ALSO INCLUDE...

- ◯ Clinical/ Progress Notes
- ◯ Demographics Sheet
- ◯ Current Medications
- ◯ Labs

BRIUMVI ORDER

Briumvi Dose: ◯ Loading Dose: 150mg IV Day 0, 450mg IV Day 15, then 450mg IV every 24 weeks **Patients Weight:** _____

◯ Maintenance Dose: 450mg IV every 24 weeks x 1 year

PreMeds: ☐ Benadryl 25 mg IV ☐ APAP 500 mg PO ☐ IV methylprednisolone 100mg

Date of last Briumvi Infusion: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____