



Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)			PRESCRIBER INFORMATION			
Name: DOB:		Preso	Prescriber Name:			
Address:		State	State License:			
City, State, Zip:		NPI #	NPI #: DEA:			
Phone: Alt. Phone:			Address:			
Email: SS#:			City, State, Zip:			
Gender: M F Weight:(lbs) Ht:					Fax:	
Allergies:			e Contact:		Phone:	
INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)						
Primary Insurance:			Secondary Insurance (If Applicable):			
Plan #:			Plan #:			
Group #:			Group #:			
RX Card (PBM):			RX Card (PBM):			
BIN: PCN:		BIN:			_ PCN:	
CLINICAL INFORMATION						
☐ G35 MS (relapsing remitting) ☐ Other (Specify ICD-10 Code):						
Lab Orders: Frequency:						
Has patient received/plans on receiving any live or live-attenuated vaccinations 4 weeks prior to starting Briumvi™ treatment? ☐ Yes ☐ No						
Has Patient received/plans on receiving any	y non-live vaccinations 2 w	eeks prior to	starting Brium	nvi™ treatment?	□ Yes □ No	
Has Quantitative Serum Immunoglobulin Screening been performed? Yes No (Serum Immunoglobulin levels:)						
Has patient received an HBV Screening? ☐ Yes ☐ No (Results: ☐ Negative ☐ Positive)						
** Obtain the following labs at prior to start of treatment and at frequency: CBC CMP CRP CRP CRP CRP CRP CRP CRP CRP CRP CR						
BRIUMVI™ ORDERS						
Prescription type: New start Restar	☐ Continued therapy Total Doses Received: Date of			of Last Injection/Infusion:		
Medication		Dose/Frequency			Refills	
	☐ First Infusion: 150 mg (1 vial)					
□ D : : : : : : :	☐ Second Infusion: 450 mg (3 vials) (2 weeks after initial dose)				D-CII.	
☐ Briumvi™ 150mg vial	☐ Subsequent Infusion: 450 mg (3 vials) once every 24 weeks			Refill:		
	☐ Other:			_		
Pre-Medication	Route			Dos	е	
☐ Acetaminophen	□ РО	□ 500mg	☐ 650mg	☐ 1000mg		
\square Methylprednisolone (Solu-Medrol)	□IV	☐ 60mg	☐ 100 mg	□mg		
☐ Diphenhydramine (Benadryl)	□ IV □ PO	☐ 25mg	☐ 50mg			
Other:						
ANAPHYLACTIC REACTION (AR):						
☐ EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary						
☐ EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg): may repeat in 3-5 mins x 1 if necessary						
☐ Diphenhydramine 50mg (1mL) - Administer 50 mg VIA slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary ☐ Methylprodesicalone 40mg, administer 40 mg IVP, or IV if no IV access.						
☐ Methylprednisolone 40mg - administer 40 mg IVP -or- IM if no IV access ☐ Sodium Chloride 0.9% 500 mL infuse IV at a rate of up to 999 mL/hr						
- Southin Chiofide 0.5% 500 file littuse iv at a fate of up to 555 file/fil						

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.



BRIUMVI™

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□ Other:	
SIGNATURE	
We hereby authorize Valustar to provide all supplies and additional services (nursing/patient training) requiprescribed in this referral.	red to provide and deliver the medicine as
X	Date:
Prescriber Signature	

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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