



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ DEA: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office 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			
<input type="checkbox"/> G35.A Relapsing-remitting multiple sclerosis	<input type="checkbox"/> G35.B0 Primary progressive multiple sclerosis, unspecified	<input type="checkbox"/> G35.B1 Active primary progressive multiple sclerosis	<input type="checkbox"/> G35.B2 Non-active primary progressive multiple sclerosis
<input type="checkbox"/> G35.C0 Secondary progressive multiple sclerosis, unspecified	<input type="checkbox"/> G35.C1 Active secondary progressive multiple sclerosis	<input type="checkbox"/> G35.CD Non-active secondary progressive multiple sclerosis	<input type="checkbox"/> G35.D Multiple sclerosis, unspecified
<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has Patient received/plans on receiving any non-live vaccinations 2 weeks prior to starting Briumvi™ treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has Quantitative Serum Immunoglobulin Screening been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No (Serum Immunoglobulin levels: _____)			
Has patient received an HBV Screening? <input type="checkbox"/> Yes <input type="checkbox"/> No (Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive)			

BRIUMVI™ ORDERS		
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____		
Medication	Dose/Frequency	Refills
<input type="checkbox"/> Briumvi™ 150mg vial	<input type="checkbox"/> First Infusion: 150 mg (1 vial) <input type="checkbox"/> Second Infusion: 450 mg (3 vials) (2 weeks after initial dose) <input type="checkbox"/> Subsequent Infusion: 450 mg (3 vials) once every 24 weeks <input type="checkbox"/> Other: _____	Refill: _____
Pre-Medication	Route	Dose
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> PO	<input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg
<input type="checkbox"/> Methylprednisolone (Solu-Medrol)	<input type="checkbox"/> IV	<input type="checkbox"/> 60mg <input type="checkbox"/> 100 mg <input type="checkbox"/> _____ mg
<input type="checkbox"/> Diphenhydramine (Benadryl)	<input type="checkbox"/> IV <input type="checkbox"/> PO	25mg <input type="checkbox"/> 50mg
Other: _____	_____	_____

INFUSION REACTION ORDERS
<b>Mild reaction protocol:</b>
<input checked="" type="checkbox"/> Diphenhydramine 25mg IV, one time, for pruritus.

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*If symptoms worsen, see orders for moderate to severe reactions.*

**Moderate reaction protocol:**

- Acetaminophen 650mg PO, one time, for pyrexia or rigors
- Diphenhydramine 50mg IV, one time, for pruritus or urticaria
- Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms

*If symptoms worsen, see interventions for severe reactions*

**Severe reaction protocol: (Call 911 if initiated):**

- Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)
- Diphenhydramine 50mg IV, one time, for respiratory symptoms, edema, or anaphylaxis
- Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis
- Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms
- Epinephrine 0.3mg/0.3mL IM into mid-antrolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen

**FLUSHING & LOCKING ORDERS**

**Flushing Protocol (>66lbs/33kg)**

**PIV and Midline:**

- 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion

**Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:**

- 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw

**Locking Protocol (>66lbs/33kg)**

**PIV and Midline:**

- Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush

**PICC:**

- Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush

**Implanted Port, Tunneled Catheter, and Non-tunneled Catheter:**

- Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush

**\*\* May substitute Dextrose 5% in Water, or alternative, for 0.9% Sodium Chloride, when indicated due to incompatibility with medications being infused**

**SIGNATURE**

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X \_\_\_\_\_

Prescriber Signature

Date: \_\_\_\_\_

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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