LAWRENCE COUNTY
Memorial Hospital
DEACONESS ILLINOIS PARTNER

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

DIAGNOSIS AND ICDE 10 CODE

☐ Multiple Sclerosis	ICD 10 Code: G35
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ The signed order form by the provider ☐ Patient demographics AND insurance information ☐ Prior authorization with reference number *Pt may be required to submit a pregnancy test prior to treatment	☐ Clinical/Progress notes (must be within 1 year) ☐ Hepatitis B Screening ☐ Serum Immunoglobulins ☐ Liver Function Testing

List of tried and failed therapies, including duration of treatment:

1) _____
2) _____

MEDICATION ORDERS

Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____ **Pt wt required for weight-based orders

Dosing	☐ First Infusion: J 2329 Briumvi 150mg IV Infusion ☐ Second Infusion: J 2329 Briumvi 450mg IV infusion (2 weeks after first infusion) ☐ Subsequent infusion: J2329 Briumvi 450mg IV infusion every 24 weeks (after first infusion and thereafter) ☐ Other: _____

Duration: ☐ x6 months ☐ x 1 year ☐ x _____ doses

PREMEDICATIONS/ LAB ORDERS

☐ Acetaminophen 500mg PO PRN ☐ CBC ☐ prior to each infusion or ☐ Frequency: _____
☐ Benadryl 25mg PO or IV ☐ CMP ☐ prior to each infusion or ☐ Frequency: _____
☐ Solu-Medrol 100mg IV Push
☐ Other: _____ Date:_____
*NOTE: Recommended to premedicate approximately 30 min prior to each infusion

ADDITIONAL ORDERS/INFORMATION

PRESCRIBER INFORMATION

Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS – BRIUMVI (UBLITUXIMAB-XIIY)