

Briumvi® (ublituximab-xiyy) Referral Form



Preferred Clinic (select one):

PATIENT INFORMATION

New Referral

Updated Referral

Referral Renewal

DOB:	Patient Name:	Patient Phone:
Patient Address:	Patient Email:	
NKDA Allergies:	Weight (lbs/kg):	Height:
ICD-10 Code (SEE BELOW):	Last Treatment Date:	Last 4 Digits SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:
Physician Preferred Method of Contact:	Email:	Fax:	Phone:

STANDING ORDERS

☒ Infusion to be administered per Vivo protocols.

LABORATORY ORDERS

CBC w/ diff every _____
CMP every _____
Hepatic Function Panel every 6 months
Quantitative IgG Levels every 12 months
Vitamin D-25-OH every 12 months

***Vivo Infusion will perform pregnancy screening prior to every infusion per Vivo policy*

BRIUMVI ADMINISTRATION

Initial Dosing: 150 mg IV followed by 450 mg IV two weeks later.

Maintenance Dosing: 450 mg IV 24 weeks after the first infusion and every 24 weeks thereafter.

REQUIRED ICD-10 CODE

G35.A Relapsing-remitting multiple sclerosis
G35.C0 Secondary progressive multiple sclerosis
G35.C1 Active secondary progressive multiple sclerosis
G35.C2 Non-active secondary progressive multiple sclerosis
G35.D Multiple sclerosis, unspecified

PREMEDICATIONS

acetaminophen (Tylenol) 500mg 650mg 1000mg PO
cetirizine (Zyrtec) 10mg PO
loratadine (Claritin) 10mg PO
diphenhydramine (Benadryl) 25mg 50mg PO IV
methylprednisolone (Solu-Medrol) 40mg 125mg IV
hydrocortisone (Solu-Cortef) 100mg IV
Other: _____
Dose: _____ Route: _____

REQUIRED DOCUMENTATION

Patient Demographics
Insurance Card/Information
Progress Notes Supporting DX
Current Medication List and H&P
Quantitative Immunoglobulin
Hep B Surface Antigen and Core AB
ALT, AST, alkaline phosphatase, and bilirubin levels

Provider Name (Print)	Provider Signature	Date
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*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Email Referrals To: referrals@vivoinfusion.com OR Fax Below

Have a Question? Call (720) 902-4111

Colorado: 303-418-4679	Massachusetts: 781-202-1629	New Jersey: 609-955-3711	Oklahoma: 918-770-4421	Virginia: 804-500-5941
Connecticut: 203-724-4838	Michigan: 833-957-2188	New York: 800-540-1852	Pennsylvania: 215-399-9244	Wisconsin: 414-600-5383
Florida: 904-930-4211	Minnesota: 763-290-0903	Ohio: 216-400-0674	Texas: 469-340-0044	

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