Provider Order Form

BRIUMVI (UBLITUXIMAB-XIIY)

Uptiv Health

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ Hepatitis B Results
☐ Quantitative serum immunoglobulin screening

PATIENT

Full Name: DOB:

Mobile Phone: Weight: ☐ lbs ☐ kg

Allergies: ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Relapsing-remitting multiple sclerosis, ICD 10: G35.A
☐ Primary progressive multiple sclerosis, unspecified, ICD 10: G35.B0
☐ Active primary progressive multiple sclerosis, ICD 10: G35.B1
☐ Non-active primary progressive multiple sclerosis, ICD 10: G35.B2
☐ Secondary progressive multiple sclerosis, unspecified, ICD 10: G35.C0
☐ Active secondary progressive multiple sclerosis, ICD 10: G35.C1
☐ Non-active secondary progressive multiple sclerosis, ICD 10: G35.C2
☐ Multiple sclerosis, unspecified, ICD 10: G35.D
**Disclaimer: After 10/1/2025 you must specify which type of MS per CMS guidelines.

PROVIDER

Provider Name: Provider NPI:

Practice Name: Referral Coordinator Name:

Practice Address:

Phone: Fax: Email:

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg
☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg
☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg
☐ Cetrizine (Zyrtec) 10 mg PO
☐ Other: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☒ Briumvi (Ublituximab-xiiy), IV	☐ 150 mg	☐ Induction Dose: 150 mg, followed by 450 mg IV 2 weeks later, then 450 mg IV every 24 weeks
	☐ 450 mg	☐ Maintenance Dose: every 24 weeks

Refills ☐ Zero ☐ 12 months ☐ _____ Order valid for 1 year unless otherwise stated. _____
☒ Flush with 0.9% sodium chloride at infusion completion.
☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other _____ ☐ at each dose ☐ every _____

SPECIAL INSTRUCTIONS

Provider Signature Date