



Select referral location:

Akron	Columbus (East Broad)	Findlay	Toledo
Athens	Columbus (Hilliard)	Liberty	Crestview Hills (NKY)
Cincinnati (Blue Ash)	Columbus (Worthington)	Mansfield	
Cincinnati (West)	Dayton (Beavercreek)	Perrysburg	
Cleveland	Dayton (Englewood)	Springfield	

**Briumvi**  
(ublituximab-xiiv)

**For new referrals, please include recent labs and last two office visit notes.**

**Fax completed form to 888-977-0914**

Phone: 877-787-8720 • www.horizoninfusions.com

**1. PATIENT INFORMATION**

Name:		DOB:	
Phone:		Other Phone:	
Email:			
Social Security #:		Allergies:	
Gender: M F	Weight: Lbs Kg		
Patient Status: New to therapy Continuing therapy		Next due date (if applicable):	

**2. INSURANCE INFORMATION (required)**

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

**3. PHYSICIAN INFORMATION**

Physician Name:		NPI#:	
License #:	TIN#:	DEA#:	
Address:			
City:		State	Zip
Office Contact:		Email:	
Office phone:		Office fax:	

**4. DIAGNOSIS INFORMATION (and year of diagnosis)**

Multiple Sclerosis ( ) ICD 10 ( ) Other: \_\_\_\_\_

**\*Hep B and IG levels required prior to initial infusion\***

**5. PRESCRIPTION INFORMATION (requires new order every 12-months)**

<b>BRIUMVI</b>	Initial	Maintenance	<b>PRE-MEDICATIONS</b>	N/A
Initial Dose: Administer 150mg intravenous infusion, followed two weeks later by 450mg intravenous infusion			Acetaminophen	500mg 650mg 1000mg
Maintenance Dose: 450mg intravenous infusion every 24 weeks			Fexofenadine (Allegra)	180mg PO (or other non-sedating antihistamine)
Vital signs per HI Protocol			Diphenhydramine (Benadryl)	25mg 50mg PO IV (requires driver)
Anaphylaxis & Hydration Management per HI Protocol			Methylprednisolone (Solu-Medrol)	40mg 80mg 100mg IV
			Prednisone	_____ mg PO
			Other	_____
			<b>POST-MEDICATIONS</b>	N/A
			Acetaminophen	500mg 650mg 1000mg
			Prednisone	_____ mg PO
			Other	_____

**6. LABS**

CBC w/Diff	Each Infusion	Other Frequency (specify): _____
CRP	Each Infusion	Other Frequency (specify): _____
CMP	Each Infusion	Other Frequency (specify): _____
ESR	Each Infusion	Other Frequency (specify): _____
Hepatic Panel	Each Infusion	Other Frequency (specify): _____
Renal Panel	Each Infusion	Other Frequency (specify): _____
Quantiferon TB Gold, annually, last completed (date): _____		
Other (specify): _____		

**7. SIGNATURE (required)**

PHYSICIAN'S SIGNATURE

DATE