



Briumvi Order Form

Select patient referral location: Anchorage Palmer Fairbanks

Please fax or securely email to 1-907-921-7669 or RX@luxinfusion.com.
For new referrals, please **include recent labs and last two office visit notes.**
Clinic Phone Number: 1-907-744-1944 · luxinfusion.com

1. PATIENT INFORMATION	
Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: M F	Weight:
Patient Status: New to therapy Continuing therapy	Next due date (if applicable):

2. PHYSICIAN INFORMATION	
Physician's Name:	NPI#:
License #: TIN#:	DEA#:
Address:	
City:	State: Zip:
Office contact:	Email:
Office phone:	Office fax:

3. DIAGNOSIS INFORMATION (and year of diagnosis)	
Multiple Sclerosis (MS) (_____) ICD 10 (<u>G35</u>)	Other (specify): _____

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

5. PRESCRIPTION INFORMATION (requires new order every 12 months)	
BRIUMVI	PRE-MEDICATIONS
Initial Maintenance	N/A
Initial Dose: Administer 150 mg over 4 hours.	Acetaminophen 500mg 650mg 1000mg PO
(Monitor in suite 1 hour post infusion)	Cetirizine (Zyrtec) 10mg PO (or other non-sedating anti-histamine)
Second Dose: Administer 450 mg 2 weeks after dose	Diphenhydramine (Benadryl) 25mg 50mg
1 over 1 hour. (Monitor in suite 1 hour post infusion)	PO IV (requires driver)
Subsequent Doses: Administer 450 mg 24 weeks after first infusion and once every 24 weeks over 1 hour.	Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV
	Prednisone _____ mg PO
Vital signs per LUX Protocol	Other: _____
Anaphylaxis & Hydration Management per LUX Protocol	POST-MEDICATIONS
	N/A
	Acetaminophen 500mg 650mg 1000mg PO
	Prednisone _____ mg PO
	Other: _____

6. SIGNATURE (required)

PHYSICIAN'S SIGNATURE _____ DATE _____