



Briumvi Order Form

Select patient referral location: Akron Athens Blue Ash Cleveland Columbus Crestview Hills
Dayton Mansfield Perrysburg Springfield Toledo West Cincinnati

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, TB, and IG levels required prior to initial infusion**

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

BRIUMVI	Initial	Maintenance	PRE-MEDICATIONS	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 _____	
			POST-MEDICATIONS	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