



Birmingham, AL
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Huntsville, AL
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Knoxville, TN
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Nashville, TN
F: 615-645-4791

Chantilly, VA
F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: M F Height: _____ Weight: _____
Phone Number: _____ Email Address: _____
Allergies: _____ Is the patient Diabetic: Y N ICD-10 Code: _____
Emergency Contact: _____ Phone Number: _____

Primary Diagnosis: _____ Multiple Sclerosis
_____ Other: _____

Please attach the following: 1. Clinical MD Notes,/History 2. Most Recent Labs 3. Copy of the patient's Insurance Card 4. Medications List 5. Immunoglobulin Panel 6. MRI Results 7. Neg Hep B Serology

Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: BRIUMVI (ublituximab-xiiy)
_____ # Refills (Recommend 5 refills)

Initial Dose: Briumvi 150 mg IV on day 1, followed by 450 mg on day
15, then 450 mg IV every 24 weeks thereafter.

Maintenance: Briumvi 450 mg IV every 24 weeks

Pre-Medication Orders:

Per infusion clinic protocol: Acetaminophen 650 mg PO, Diphenhydramine 25 mg IV, and Methylprednisolone 100 mg IV
(30 minutes prior to start of infusion)
Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)
By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

Physician's NPI# Physician's Address

Prescriber's Signature Date

Legal Notice: The prescriber is to comply with their state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the recipient named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. This prescription may be filled out at a pharmacy of the patient's choice. ©2025 ContinuumRx Services, Inc. All rights reserved.