



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ DEA: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION

G35 MS (relapsing remitting) Other (Specify ICD-10 Code): _____

Lab Orders: _____ Frequency: _____

Has patient received/plans on receiving any live or live-attenuated vaccinations 4 weeks prior to starting Briumvi™ treatment? Yes No

Has Patient received/plans on receiving any non-live vaccinations 2 weeks prior to starting Briumvi™ treatment? Yes No

Has Quantitative Serum Immunoglobulin Screening been performed? Yes No (Serum Immunoglobulin levels: _____)

Has patient received an HBV Screening? Yes No (Results: Negative Positive)

BRIUMVI™ ORDERS

Prescription type: New start Restart Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose/Frequency	Refills
<input type="checkbox"/> Briumvi™ 150mg vial	<input type="checkbox"/> First Infusion: 150 mg (1 vial) <input type="checkbox"/> Second Infusion: 450 mg (3 vials) (2 weeks after initial dose) <input type="checkbox"/> Subsequent Infusion: 450 mg (3 vials) once every 24 weeks <input type="checkbox"/> Other: _____	Refill: _____
Pre-Medication	Route	Dose
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> PO	<input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg
<input type="checkbox"/> Methylprednisolone (Solu-Medrol)	<input type="checkbox"/> IV	<input type="checkbox"/> 60mg <input type="checkbox"/> 100 mg <input type="checkbox"/> _____mg
<input type="checkbox"/> Diphenhydramine (Benadryl)	<input type="checkbox"/> IV <input type="checkbox"/> PO	<input type="checkbox"/> 25mg <input type="checkbox"/> 50mg
Other: _____	_____	_____

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X _____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.