TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

BRIUMVI™

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____
NPI #: _____ DEA: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Office Contact: _____ Phone: _____

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

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

Secondary Insurance (If Applicable):
Secondary Insurance: _____
Plan #: _____
Group #: _____

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
☐ Briumvi™ 150mg vial	☐ First Infusion: 150 mg (1 vial) ☐ Second Infusion: 450 mg (3 vials) (2 weeks after initial dose) ☐ Subsequent Infusion: 450 mg (3 vials) once every 24 weeks ☐ Other: _____	Refill: _____

Pre-Medication	Route	Dose
☐ Acetaminophen	☐ PO	☐ 500mg ☐ 650mg ☐ 1000mg
☐ Methylprednisolone (Solu-Medrol)	☐ IV	☐ 60mg ☐ 100 mg ☐ _____mg
☐ Diphenhydramine (Benadryl)	☐ IV ☐ PO	☐ 25mg ☐ 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.