Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

Briumvi Request Form

2301 Evesham Road, Building 800, Suite 115
Voorhees, New Jersey 08043
T. (866)497-0905
F.(609)228-9798 attn: Idyllic Infusion Coordinator

MEDICATION REQUESTED	
DATE:	
REFERRING PROVIDER INFORMATION	
Requesting Provider Name NPI Tax ID#	**Name:** **NPI:** **Tax ID#**
Phone Number	
Fax Number	
Practice Contact (Name/Extension/email	**Email:** **Phone Number: Ext:**
We will gladly remind your patient to schedule routine follow-up visits with your office. **Return to Referring Provider (frequency): EVERY _____ WKS / MOS**	
Patient Name	
Date of Birth	/ /
Weight/Height	
Insurance(s): include copies of front and back	
Preferred Treatment Location	☐ Voorhees ☐ Moorestown ☐ Wall/Manasquan ☐ Sewell ☒ Hamilton ☐ Galloway
Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:

The referring provider is the primary provider responsible for medication management, labs, scripts, and the patient's treatment plan.

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Name (last, first) _____DOB: _____

ALL OF THE FOLLOWING INFORMATION IS REQUIRED :

Primary DX: □G35 Relapsing-Remitting □G35 Secondary Progressive

□NKDA
□Signed order from by the ordering physician
□Patient demographic and insurance information
□clinical/progress notes supporting primary DX
□Labs and Tests supporting primary diagnosis
□Hepatitis Test results: HBsAg & Total HepB Core Antibody
□Immunoglobulin panel

Current MS treatment and end of current therapy date:

Premedications required:
□Acetaminophen PO □500 MG □650MG □1000MG
□diphenhydramine PO/IV □25MG □50MG (If route is not selected PO will be administered)
□methylprednisolone □100MG
□non drowsy antihistamine
□Other

PLEASE NOTE:

- Please attach a copy of the medication order to this document. Prescription should include standard information as well as specific instructions if loading doses of desired RX is required. ** NOTE ** Please do NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
- ***OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS***
- *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*
- Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- *Please notify our office if medication will be discontinued.*

❒ Patient has been educated by the ordering provider on medication.

Ordering provider signature:

_____

ARBDA/IDYLLIC NPI: 1427622661 TAX ID: 85-1604336