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**: | |
| **NAME OF DRUG BEING REQUESTED:** | **Briumvi** |
| **REFERRING PROVIDER INFORMATION** | |
| **Requesting Provider Name NPI Tax ID#** | **Name:**<br>**NPI:**<br>**Tax ID#** |
| **Phone Number** | |
| **Fax Number** | |
| **Practice Contact (Name/Extension/email** | **Email:**<br>**Phone Number:** **Ext:** |
| ***We will gladly remind your patient to schedule routine follow-up visits with your office.***<br><br>**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<br>☐ Wall/Manasquan ☐ Sewell<br>☒ Hamilton ☐ Galloway |
| **Primary Care Physician (Name / Phone Number)** | PCP Name:<br>PCP Phone Number: |

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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.*

**Ordering provider signature:**

_____

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