ASTHMA & IMMUNOLOGY ENROLLMENT FORM

APEXInfusion Ph. (877) 501-6800 F. (877) 501-6844

Date: / /

Patient Name:_____ DOB: / / Height:_____ Weight:_____

Ship to:
- ☐ Patient
- ☐ MD Office
- ☐ AIS Location:_____

Allergies:_____ Email:_____

Address:_____ Ph:_____

Prescriber:_____ Ph:_____ Fax:_____

PLEASE ATTACH ORIGINAL PRESCRIPTION ORDERS & FAX THE FOLLOWING:

- Patient demographics
- Face sheet
- Insurance information
- Medications and therapies tried and failed
- H&P
- Baseline assessment, including detailed patient symptoms
- Labs: - Antibody testing results
  - Most recent BUN/SCr and IgA level
  - EMG/NCV studies

DIAGNOSIS

- ☐ D80.0 - Hereditary hypogammaglobulinemia
- ☐ D80.1 - Nonfamilial hypogammaglobulinemia
- ☐ D80.3 - Selective deficiency of IgG subclasses
- ☐ D80.4 - Selective deficiency of IgM
- ☐ D83.0 - Common variable immunodeficiency
- ☐ D84.9 - Immunodeficiency, unspecified
- ☐ J33.0 - Polyp of nasal cavity
- ☐ J45.40 - Moderate persistent asthma, uncomplicated
- ☐ J45.41 - Moderate persistent asthma w/ (acute) exacerbation
- ☐ J45.50 - Severe persistent asthma, uncomplicated
- ☐ J45.909 - Asthma, unspecified
- ☐ K20.0 - Eosinophilic esophagitis
- ☐ L20.9 - Atopic dermatitis, unspecified
- ☐ L50.1 - Idiopathic urticaria
- ☐ L50.8 - Other urticaria
- ☐ Other (ICD-10 required): _____
- ☐ D86.9 - Sarcoidosis, unspecified
- ☐ D69.36 - Immune thrombocytopenia (ITP)

Eosinophil count: _____ cells per uL IgE Levels: _____

Date of Test: / /

Injection Training or Home Health RN visit is necessary: ☐ Yes ☐ No

☐ Patient is not a candidate for surgery.

Rationale:_____

IMMUNE GLOBULIN PRESCRIPTION (IVIG)

Loading Dose: IVIG ____ gm per kg given over ____ day(s)

OR ____ gm daily for ____ day(s)

Maintenance: IVIG ____ gm per kg given over ____ day(s)

OR ____ gm daily for ____ day(s)

☐ Repeat course every ____ week(s). Refill x 1yr.

SUBCUTANEOUS IMMUNE GLOBULIN PRESCRIPTION (SCIG):

SCIG ____ gm monthly OR ____ gm every ____ weeks. Refill x 1yr.

Pharmacy to select number of infusion sites and needle length.

- OK to round to the nearest vial size.
- +/- 4 days to allow scheduling flexibility.

Multiple doses will be administered on consecutive days unless ordered otherwise. ☐ **Non-consecutive days OK**

MEDICATION ORDER	ADMINISTRATION
☐ **Fasenra™** (benralizumab)	☐ **Starter Dose:** Administer 30mg SUBQ every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter. ☐ **Maintenance Dose:** Administer 30mg SUBQ every 8 weeks.
☐ **Nucala®** (mepolizumab)	☐ Inject 100mg SUBQ once every 4 weeks into the upper arm, thigh, or abdomen. **Supplies will be sent with shipment unless indicated.** ☐ **No Supplies**
☐ **Tezspire® PFS** (tezepelumab-ekko)	☐ Inject 210mg subcutaneously once every 4 weeks.
☐ **Xolair®** (Omalizumab) ☐ **Asthma** ☐ **CSU** ☐ **Ig-E mediated food allergy**	☐ Administer 75mg dose SUBQ every ☐ 2 weeks ☐ 4 weeks ☐ Administer 150mg dose SUBQ every ☐ 2 weeks ☐ 4 weeks ☐ Administer 300mg dose SUBQ every ☐ 2 weeks ☐ 4 weeks ☐ Other: Administer ____ mg per dose SUBQ every ☐ 2 weeks ☐ 4 weeks **Supplies will be sent with shipment unless indicated.** ☐ **No Supplies**

☐ **Other**

PRE-MEDICATION ORDERS & OTHER MEDICATIONS

Administer pre-medications 30 minutes before every infusion/injection:

☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO

☐ Diphenhydramine (Benadryl) PO ☐ 25mg ☐ 50mg

☐ Hydration: Solution _____ volume _____ to be infused ☐ Pre OR ☐ Post

☐ Other: _____

Flush Protocol - Flushing per S.A.S.H. protocol (Saline, Administer medication, Saline, Heparin) specific volumes and concentrations based on patient's line type.