

Date: / / Patient Name: _____ DOB: / / Allergies: _____ Height: _____ Weight: _____
Administration at:
☐ Home Address: _____
☐ MD Office Email: _____ Home Ph: _____ Cell: _____
☐ Infusion Suite: _____

Provider: _____ Name: _____ Ph: _____ Fax: _____
 Office Contact: _____ Email: _____ Ph: _____

DIAGNOSIS

- | | |
|--|---|
| ☐ G61.81 - CIDP (Chronic Inflammatory Demyelinating Polyneuritis) | ☐ D69.3 - Immune thrombocytopenic purpura |
| ☐ G61.0 - Guillain-Barré syndrome | ☐ G35.A - Relapsing-remitting multiple sclerosis |
| ☐ G61.82 - Multifocal motor neuropathy (MMN) | ☐ G35.B - Primary progressive multiple sclerosis |
| ☐ G70.01 - Myasthenia gravis with (acute) exacerbation | ☐ G35.C - Secondary progressive multiple sclerosis |
| ☐ M33.22 - Polymyositis with myopathy | ☐ M32.9 - Systemic lupus erythematosus (SLE) |
| ☐ G25.82 - Stiff-person syndrome | ☐ D89.9 - Disorder involving the immune mechanism (PANS) |
| ☐ M33.10 - Dermatomyositis | ☐ G13.0 - Paraneoplastic neuromyopathy and neuropathy |
| ☐ L10.9 - Pemphigus | ☐ G70.80 - Lambert-Eaton syndrome, unspecified |
| ☐ L12.0 - Pemphigoid | ☐ Other: _____ |
| ☐ G04.81 - Autoimmune encephopathy | |

PLEASE FAX THE FOLLOWING:

- Patient demographics/insurance information
- H&P/clinical summary/notes
- Therapies tried and failed
- Diagnostic test results: recent CBC/diff, CMP, BUN/SCr, EMG/NCS, biopsy, etc., as required

MEDICATION INFORMATION

☐ Intravenous Immunoglobulin

☐ 0.4 gm/kg ☐ 1 gm/kg ☐ 2 gm/kg ☐ _____ gm

Infuse over _____ days (consecutive/non-consecutive days) every _____ week(s). Duration _____ month(s).

Ramp up infusion rate up gradually to max rate as per Apex Infusion protocol, clinical appropriateness, manufacturer guidelines, and patient tolerance.

☐ Other: _____

ANAPHYLAXIS PROTOCOL

Anaphylaxis kit is sent as per Apex Infusion protocol.

IV ACCESS DEVICE FLUSHING PROTOCOL

Flushing supplies are sent based on IV line type following SAS/SASH technique as per Apex Infusion protocol.

PRE-MEDICATIONS

Acetaminophen 650 mg **OR** _____ mg PO as needed prior to infusion

Methylprednisolone _____ mg IV as needed prior to infusion

Diphenhydramine 25mg PO **OR** _____ mg ☐ PO ☐ IV as needed prior to infusion ☐ Other pre-med:

Hydration _____ mL NS ☐ Pre-Infusion ☐ Post-Infusion ☐ Both

LABS

☐ CBC/diff ☐ CMP ☐ Other: _____

☐ Frequency: _____

IV LINE

☐ Peripheral ☐ Central ☐ Port ☐ Other: _____