NEUROLOGY ENROLLMENT FORM

APEXInfusion

Phone. (877) 501-6800 Fax. (877) 501-6844

Date: / /

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

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

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

- ☐ G61.81 – CIDP (Chronic Inflammatory Demyelinating Polyneuritis)
- ☐ M33.10 – Dermatomyositis
- ☐ G61.0 – Guillian-Barré syndrome
- ☐ G70.80 – Lambert-Eaton syndrome, unspecified
- ☐ G61.82 – Multifocal motor neuropathy (MMN)
- ☐ G35.A – Relapsing-remitting multiple sclerosis
- ☐ G35.B – Primary progressive multiple sclerosis
- ☐ G35.C – Secondary progressive multiple sclerosis
- ☐ G70.01 – Myasthenia gravis with (acute) exacerbation
- ☐ G13.0 – Paraneoplastic neuromyopathy and neuropathy
- ☐ M33.22 – Polymyositis with myopathy
- ☐ G25.82 – Stiff-man syndrome
- ☐ Other:_____

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.

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

PRESCRIPTION ORDER	ADMINISTRATION	
☐ **Briumvi®** (ublituximab-xiiy)	☐ **Loading dose:** Infuse Briumvi 150mg intravenously once on day 1, followed by 450mg intravenously once 2 weeks later.	☐ **Maintenance dose:** Infuse Briumvi 450mg intravenously once every 24 weeks (beginning 24 weeks after the first 150mg dose).
☐ **Ocrevus®** (ocrelizumab)	☐ **Loading dose:** Infuse Ocrevus 300mg / 250ml NS intravenously on weeks 0 and 2. Infuse over 2.5 hours.	☐ **Maintenance dose:** Infuse Ocrevus 600mg / 500ml NS intravenously over approximately 2 hours, every 6 months, starting 6 months after week 0.
☐ **Ocrevus Zunovo®** (ocrelizumab and hyaluronidase-ocsq)	Ocrelizumab 920mg/Hyaluronidase 23,000 units subcutaneously every 6 months.	
☐ **Rituxan®** (rituximab) ☐ **Truxima®** (rituximab-abbs)	1000mg intravenously on day 1 and 15 for 2 doses.	Then 1000mg intravenously once every 6 to 12 months.
☐ **Tysabri®** (natalizumab)	Infuse 300mg dose intravenously every four weeks.	

☐ **Other**

PRE-MEDICATION ORDERS & OTHER MEDICATIONS

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

Infusion supplies as per protocol. Anaphylaxis Kit orders as per protocol.

- ☐ Acetaminophen _____ mg PO prior to infusion
- ☐ Diphenhydramine _____ mg PO
- ☐ Diphenhydramine _____ mg IV
- ☐ Methylprednisolone 100mg IVP
- ☐ Other:_____