APEX Infusion Pharmacy

APEX INFUSION REPRESENTATIVE:

GASTROENTEROLOGY ENROLLMENT FORM

PHONE - (877)501-6800 - FAX (877)501-6844 - www.Apex-iv.com

PATIENT INFORMATION

Patient Name	Parent/Guardian *(if applicable)*		☐ All Insurance Info Attached
Address	City	State	Zip
Main Phone	Alternate Phone	Email Address	
Date of Birth	Male Female	Height *(required)* inches	Weight *(required)* pounds
Other Drugs Used to Treat Patient's Condition			
Home Infusion Ship to MDO	Arcadia Infusion Suite	Allergies	

CLINICAL INFORMATION - PRIMARY DIAGNOSIS - ICD-10

Adult Crohn's Disease (CD)	Adult Ulcerative Colitis (UC)	Pediatric Crohn's Disease	Travelers' Diarrhea	Hepatic Encephalopathy	Other
ICD-10____________	ICD-10____________	ICD-10____________	ICD-10____________	ICD-10____________	ICD-10____________

PRESCRIPTION AND ORDERS

PRESCRIPTION	DIRECTIONS	QUANTITY Refills	FORMS
Cimzia® (certolizumab)	Inject 400 mg subcut at weeks 0, 2 and 4 Inject 400 mg subcut every 4 weeks	6 X 200 mg/mL 2 X 200 mg/mL	PFS Vials
Entyvio® (vedolizumab)	Infuse IV 300mg weeks 0, 2 and 6 Infuse IV 300 mg every 8 weeks	3 X 300 mg/mL 1X 300 mg/mL	Vials
Humira® (adalimumab)	Starter Dose: Inject 160 mg subcut on day 1, then 80 mg on day 15 Maintenance Dose: Two weeks later (Day 29) begin a maintenance dose of 40 mg every other week.	3 X 80 mg/0.8mL CF 2 X 40 mg/0.8mL	Starter Kit Pens PFS
Inflectra® (infliximab-dyyb)	Infuse IV 5 mg/kg or ____ mg week 0, 2 and 6 Infuse IV 5 mg/kg or ____ mg every 8 weeks	98 day supply (induction) 56 day supply	Vials
Remicade® (infliximab)	Infuse IV 5 mg/kg or ____ mg week 0, 2 and 6 Infuse IV 5 mg/kg or ____ every 8 weeks	56 day supply	Vials
Simponi® (golimumab)	Inject 200 mg subcut at week 0, then 100 mg at week 2 Inject 100 mg subcut every 4 weeks	3 X 100 mg/mL 1 X 100 mg/mL	SmartJect® Autoinjector PFS
Stelara® ustekinumab)	Infuse 520 mg intravenously over no less than one hour (>85kg) Inject 90 mg subcut 8 weeks following initial intravenous dose, then every 8 weeks thereafter	4 X 130 mg/26mL 1 X 90 mg/mL 60 X 10 mg	Vials PFS
Xeljanz® (tofacitinib)	Take 10 mg by mouth twice daily	28 day supply	Tablets
Xifaxan® (rifaximin)	Take 550 mg by mouth twice daily Take 1 tablet by mouth three times a day	60 X 550mg 42 X 550 mg	Tablets
Low Dose Naltrexone (LDN)			

Physician Name: ______________________________

Address: ______________________________

City: ________________ State: _______ Zip: ____________

Prescriber's Signature (no stamps) ______________________________

License: ____________________

DEA: ____________________

NPI: ____________________

By signing this form and utilizing our services, you are authorizing Apex Infusion Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance.