APEX Infusion Pharmacy

APEX INFUSION REPRESENTATIVE:

NEUROLOGY 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

☐ Anti-AChR+ generalized MyastheniaGravis (gMG)

☐ Anti-AQP4 Antibody-Positive Neuromyelitis Optica Spectrum Disorder (NMOSD)

☐ Multiple Sclerosis (MS)
☐ Relapsing Multiple Sclerosis (RMS)
☐ Relapsing Remitting Multiple Sclerosis (RRMS)

☐ Migraine
☐ Other:

PRESCRIPTION AND ORDERS

PRESCRIPTION	DIRECTIONS		QUANTITY	FORMS
Avonex® (interferon beta-1a)	☐ Week 1 Inject 7.5 mcg (0.125 mL) intramuscularly once weekly; Week 2: Inject 15 mcg (0.25 mL) intramuscularly once weekly; Week 3: Inject 22.5 mcg (0.375 mL) intramuscularly once weekly; Week 4: Inject 30 mcg (0.5 mL) intramuscularly once weekly	☐ Refills x 1 Year	☐ 4 x 30 mcg	☐ Pens ☐ PFS ☐ Vials
Betaseron® (interferon beta-1b)	☐ Week 1-2: Inject 0.0625 mg (0.25 mL) subcut every other day; Week 3-4: Inject 0.125 mg (0.5 mL) subcut every other day. Week 5-6: Inject 0.1875 mg (0.75 mL) subcut every other day: Week 7-8: Inject 0.25 mg (1 mL) subcut every other day.	☐ Refills x 1 Year	☐ 14 x 0.3 mg	☐ Vials
Copaxone® (glatiramer acetate)	☐ Inject 20 mg subcut once daily. ☐ Inject 40 mg subcut three times per week at least 48 hours apart.	☐ Refills x 1 Year	☐ 30 x 20 mg ☐ 12 x 40 mg	☐ PFS
Dimenthyl Fumarate	☐ Take 120 mg by mouth twice daily for 7 days, then 240 mg by mouth twice daily thereafter. ☐ Take 240 mg by mouth twice daily.	☐ Refills x 1 Year	☐ 30-day starter pack ☐ 60 x 240 mg capsules	☐ Capsules
Glatiramer Acetate	☐ Inject 20 mg subcut once daily. ☐ Inject 40 mg subcut three times per week at least 48 hours apart.	☐ Refills x 1 Year	☐ 30 x 20 mg ☐ 12 x 40 mg	☐ PFS
Gilenya® (fingolimod)	☐ Take 0.5 mg by mouth once daily.	☐ Refills x 1 Year	☐ 30 x 0.5 mg capsules	☐ Capsules
Extavia® (interferon beta-1b)	☐ Week 1-2: Inject 0.0625 mg (0.25 mL) subcut every other day. Week 3-4: Inject 0.125 mg (0.5 mL) subcut every other day. Week 5-6: Inject 0.1875 mg (0.75 mL) subcut every other day. Week 7-8: Inject 0.25 mg (1 mL) subcut every other day.	☐ Refills x 1 Year	☐ 15 x 0.3 mg	☐ Vials
Kesimpta® (ofatumumab)	☐ Inject 20mg subcutaneously weekly for 3 weeks (weeks 0, 1, and 2) ☐ Inject 20mg subcutaneously once every 4 weeks, starting week 4	☐ Refills x 1 Year	☐ Kesimpta : 20mg	☐ PFS
Lemtrada® (alemtuzumab)	☐ Infuse First Course 12 mg/day intravenously on 5 consecutive days. Infuse Second course 12 mg/day intravenously on 3 consecutive days, 12 months after first treatment course. Last treatment on:	☐ Refills x 1 Year	☐ Lemtrada: 12mg	☐ Vials
Soliris® (eculizumab)	☐ Infuse ____mg/mcg intravenously weekly for the first 4 weeks, followed by 1200 mg for the fifth dose 1 week later, then 1200 mg every 2 weeks thereafter.	☐ Refills x 1 Year	☐ Soliris: 4 x 300mcg	☐ Vials
Tysabri® (eculizumab)	☐ Infuse ____mg/mcg intravenously every four weeks.	☐ Refills x 1 Year	☐ Tysabri: 300mg	☐ Vials
Vyepti® (eptinezumab)	☐ Infuse ____mg/mcg intravenously every 3 months.	☐ Refills x 1 Year	☐ 1 x 100mg and 3x 100mg	☐ Vials
Other				

Physician Name: _____ License: _____

Address: _____ DEA: _____

City: _____ State: _____ Zip: _____ NPI: _____

Prescriber's Signature (no stamps) _____ Specialty: _____

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.