NEW PATIENT REFERRAL GUIDE

FOR HOME INFUSION AND AMBULATORY INFUSION SUITE (AIS) PATIENTS

1) TO REFER A PATIENT: We can offer access to care in the home setting or at one of our convenient infusion suite locations. Please see infusion suite directory and insurance list within this packet.

Please fax any of the following that are available (Approval, Insurance Card, Prescription/Orders, Chart Notes). We will contact the provider where necessary to obtain remaining documents required for authorization, etc.)

Phone: 877-501-6800, 562-597-6800
Fax: 877-501-6844, 562-597-6844

2) COMPANY CONTACTS: Please see key contacts below who are available to assist:

INTAKE/AUTHORIZATIONS:

Erika Mendizabal /Intake Coordinator

Phone: 562-597-6800 ext. 1012

Email: emendizabal@apexinfusioncare.com

PHARMACY MANAGER:

Hector Gutierrez, Pharmacy Manager

Phone: 562-597-6800 (ask for Hector)

Email: hgutierrez@apexinfusioncare.com

PHARMACIST IN CHARGE:

Yoli Mansour, PharmD, Pharmacist in Charge (PIC)

Phone: 562-597-6800 ext 1015

Email: ymansour@apexinfusioncare.com

3) FIELD SUPPORT: please contact Jesse White, Regional Sales Director, for a roster and territory assignments.

Jesse White, MHA
Phone: 323-516-5958
Email: jwhite@marinrx.com

APEX INFUSION REPRESENTATIVE:

APEXInfusion

ASTHMA/IMMUNOLOGY 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

Allergies

☐ Home Infusion ☐ Ship to MDO ☐ Ambulatory Infusion Suite

Patient Status: ☐ New to therapy ☐ Continuing therapy ☐ Order Change (new order required) ☐ d/c infusion(indicate name of drug)

CLINICAL INFORMATION - PRIMARY DIAGNOSIS - ICD-10

☐ Primary Immunodeficiency Disease
☐ Atopic Dermatitis
☐ Severe Asthma
☐ Severe Persistent Asthma, uncomplicated
☐ Idiopathic Urticaria
☐ Chronic Urticaria
☐ Congenital Hypogammaglobulinemia
☐ Selective IgG Immunodeficiency
☐ Selective IgM Immunodeficiency
☐ Other Selective Immunoglobulin deficiencies
☐ Other: _____

PRESCRIPTION AND ORDERS

PRESCRIPTION	DIRECTIONS	QUANTITY Refills	FORMS
Fasenra® (benralizumab)	☐ 30mg/mL ☐ Inject 30mg subcutaneously every 4 weeks for the first 3 doses, and then once every 8 weeks	☐ _____	☐ PFS
Tezspire™ (tezepelumab-ekko)	☐ Number of 210mg/1.91 mL vials _____ ☐ Tezspire PFS 210mg/1.91mL ☐ Inject 210 mg once every 4 weeks	☐ _____	☐ Vials ☐ PFS
Dupixent® (dupilumab)	☐ Inject 600 mg subcut on day 1 ☐ Inject 600 mg subcut at day 15 and every 2 weeks thereafter ☐ 2 x 300 mg/2ml	☐ _____	☐ PFS
Nucala® (mepolizumab)	☐ Inject 100 mg subcutaneously once every 4 weeks into the upper arm, thigh or abdomen ☐ Other _____ sometimes dosed at 300mg or as low as 40mg for pediatric patients	☐ _____	☐ PFS
Firazyr® (icatibant)	☐ 30mg/3ml PFS 30mg SQ in the abdominal ☐ 30mg SQ in the abdominal area. If response is inadequate or symptoms recur, additional injections of 30 mg may be administered at intervals of at least 6 hours. Do not administer more than 3 injections in 24 hours	☐ _____	☐ PFS
Other _____			

EPI Pen/ Observation Requirements

☐ Patient is required to have Epi Pen with each treatment
☐ Patient is NOT required to have Epi Pen
☐ Patient is required to stay for 30 minutes observation post injection/infusion
☐ Patient is NOT required to stay for observation time
☐ Other_____

Nursing

☐ Provide nursing care per Apex Infusion protocol including reaction management and post-infusion/injection observation
☐ Other_____

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.

Immunoglobulin Referral Form

APEXInfusion

Phone: 1-877-501-6800
Fax: 1-877-501-6844

✂ Please detach before submitting to a pharmacy – tear here.

PATIENT INFORMATION

IG specialist Name: _____
Phone: _____

Patient ☐ see attached Gender: ○ Male ○ Female
Patient name: _____
DOB: _____ SSN: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Cell: _____
Emergency contact: _____
Phone: _____ Relationship: _____

Insurance ☐ Front and back of insurance card to follow

	Primary	Secondary
Insurance:		
Phone:		
Policy #:		
Group:		

Primary diagnosis

- ☐ Acute Infective Polyneuritis (Guillain–Barre Syndrome)
- ☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- ☐ Critical Illness Polyneuropathy (Acute Motor Neuropathy)
- ☐ Dermatomyositis
- ☐ Multifocal Motor Neuropathy (MMN)
- ☐ Multiple Sclerosis (MS)
- ☐ Myasthenia Gravis with (Acute) Exacerbation
- ☐ Myasthenia Gravis without (Acute) Exacerbation
- ☐ Peripheral Neuropathy (Unspecified)
- ☐ Polymyositis
- ☐ Stiff-Person Syndrome
- ☐ Other: _____

Medical assessment

Height: _____ Weight: _____ ○ lbs ○ kg
Current medications: ○ Yes ○ No
If yes, list or attach: _____
Allergies: _____

PRESCRIPTION ORDERS

Immune Globulin Directions:

- ☐ No preference
- ☐ Preferred product: _____
- ☐ Infuse IV ☐ Infuse SC
- ☑ Per manufacturer guidelines or as written below:
- ☑ May round to the nearest 5gm vial size

Initial: _____ gm/kg divided over _____ days
Ongoing: gm/kg divided over _____ days
every _____ weeks for _____ cycles

Quantity/Refills:

- ☐ 1-month supply; refill x 12 months unless otherwise noted
- ☐ Other:

☐ Nursing and other orders:

- ☑ Administer IVIG or teach SCIG self-administration, via pump
- ☑ Ambulatory pump if required for infusion
- ☑ Initiate access device (insert peripheral IV, SC needles, access implanted port, or use existing PICC)
- ☑ Flush PIV with 5mL NS (for other orders, contact physician)
- ☐ Obtain labs (list): _____

Lab frequency: ☐ Once ☐ Monthly ☐ Other:

Pre-medications 30 minutes before start of IG:

- ☐ Acetaminophen PO ○ 325 mg ○ 500 mg ○ 650 mg
- ☐ Diphenhydramine PO ○ 25 mg ○ 50 mg
- ☐ Hydration, solution: _____ Volume _____ mL
- ☐ Other: _____

☑ Infusion reaction management and kit order

Mild	Slow infusion rate by 50% until symptoms resolve Diphenhydramine PO ○ 25 mg ○ 50 mg ☐ other: _____
Moderate	Stop infusion, resume at 50% when symptoms resolve Diphenhydramine IV ○ 25 mg ○ 50 mg ☐ other: _____
Severe (Anaphylaxis) *Call 911*	Stop infusion; initiate 0.9% NaCl 500 mL IV Administer epinephrine 1 mg/mL by weight (Wt): Wt > 66 lbs (30 kg) = 0.3 mg/.3mL | Wt 33 - 66 lbs (15 - 30 kg) = 0.15 mg/0.15mL | Wt < 33 lbs (<15 kg) = 0.01 mg/kg Repeat epinephrine in 5-15 min if symptoms continue. Administer CPR if needed until EMS arrives.

PHYSICIAN INFORMATION

Name: _____ Address: _____
Practice: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ NPI: _____ Contact: _____

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

Substitution permissible Signature: _____ Date: _____ *Dispense as written* Signature: _____

APEX Infusion
Reaching New Horizons in Personalized Care

(8/16/22)
TAX ID: 471912488
NPI: 1457602294

Locations & Hours of Operation

We currently accept free drug on a case by case basis. **We accept chronic & acute patients.**

Apex Infusion | **Arcadia AIS**

289 W Huntington Dr, Ste 301
Arcadia, CA 91007

Chairs: 3 | **Pumps:** Yes

Monday - Friday: **9am to 5pm**
Saturday - Sunday: **9am to 5pm**
By appointment only.

Apex Infusion | **Lancaster/Palmdale AIS**

1601 West Avenue J, Ste 104
Lancaster, CA 93534

Chairs: 3 | **Pumps:** Yes

Monday - Friday: **9am to 5pm**
Saturday: **9am to 2pm**
By appointment only.

Apex Infusion | **Long Beach AIS**

3299 E Hill Street, Ste 301
Signal Hill, CA 90755

Chairs: 2 | **Pumps:** Yes

Monday - Friday: **9am to 5pm**
By appointment only.

Apex Infusion | **Santa Clarita AIS**

23928 Lyons Ave, Ste 208
Newhall, CA 91321

Chairs: 3 | **Pumps:** Yes

Monday, Wednesday, Friday:
9am to 5pm
By appointment only.

Apex Infusion | **San Rafael AIS**

55 Mitchell Blvd Ste 11
San Rafael, CA 94903

Chairs: 5 | **Pumps:** Yes

Monday - Friday:
9am to 5pm
By appointment only.

Apex Infusion | **Ventura AIS**

5720 Ralston Street, Ste 205
Ventura, CA 93003

Chairs: 2 | **Pumps:** Yes

Monday, Wednesday, Thursday: **9am to 5pm**
Saturday - Sunday: **9am to 5pm**
By appointment only.

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Reaching New Horizons in Personalized Care

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

IN-NETWORK INSURANCE PLANS FOR

APEX INFUSION SUITES & HOME INFUSION

MEDICARE	MANAGED CARE	COMMERCIAL
AARP Argus CVS Caremark Catalyst Elevate Express Scripts Humana MedImpact Navitus SilverScript WellCare	Blue Cross Medi-Cal Blue Shield Promise HP (Care 1st) Brand New Day California Children Services (CCS) CalOptima Central Health Plan of CA Citrus Valley Medical Group Easy Choice Health Plan Facey Medical Group (by plan) First Care Advantage Gold Coast Health Plan Global Care IPA HealthCare LA IPA HealthNet Medi-Cal LACARE Health Plan Medicare Medi-Cal Molina Motion Picture (Blue Cross) MultiPlan Orchid Medical Prospect Medical Group SCAN Health Seaview IPA (by plan) South Atlantic Medical Group Tricare Triwest Ventura County Health Care Plan Wellcare Health	**Anthem Blue Cross of CA** **Blue Shield of CA** **Cigna** **Humana**