

Immunoglobulin Prescription Form Please fax completed order form to 256.837.2465

after blood draw

NO Heparin needed

Groshong PICC, Midline

360F Quality Circle | Suite 630 | Huntsville, AL 35806

OFFICE: 800.838.2464 F/	AX: 256.837.2465	<u>Prescription:</u>					
Demographic Information:		☐ Intravenous Immunoglobulin ☐ Subcutaneous Immunoglobulin					
<u>Demographic Illiornia</u>	tion:	□ 0.4 gm/kg □1gm/kg □2gm/kg □	grams				
Patient Name Date of Birth		Infuse: ☐ IV daily x day(s); repeat every	week(s) x	cycles	Infuse grams using sites		
Home Address		Hydration order:mls NS iv to be infused prior/post IVIG. formonths. □ Pre-medications: Acetaminophen 650mg PO 30 mins prior to infusion □ Other Pre-medications: Diphenhydramine 25mg PO 30 mins prior to infusion					
City, State, Zip		Diphennyaranine 25mg PO 30	o mins prior to iniusio	[]			
Home Phone	Mobile or Work Phone	Clinical Information: Patient Weight: Height: Allergies:					
Primary Insurance Name		 IV access [for IVIg patients only]: 		□ Nur	se to place PIV prior to the	erapy	
Primary Insurance ID Primary Insurance Group		Diagnosis	ICD-10	Diagr	Diagnosis		ICD-10
		Neuromuscular:		Immune	e Deficiency:		
Insured Name	Insured Date of Birth	☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)) G61.81		☐ CVID w/ Predominant Immunoregulatory T-Cell Disorders		D83.1
		□ Dermatopolymyositis	M33.90		ned Immunodeficiency, Unspecified		D81.9 D83.9
Carandam Incurance Name	Incurance Croun	☐ Guillain-Barre Syndrome (GBS)	G61.0		☐ Common Variable Immunodeficiency, Unspecified		
Secondary Insurance Name Insurance ID Insurance Group		☐ Multifocal Motor Neuropathy	G61.82		☐ Hereditary Hypogammaglobulinemia		D80.0
		☐ Myasthenia Gravis (MG)	G70.0		nodeficiency with Increased IgM		D80.5
Secondary Insurance ID Secondary Insurance Group		☐ Myasthenia Gravis with (Acute) Exacerbation	G70.01		□ Nonfamilial Hypogammaglobulinemia		D80.1 D81.89
		□ Polymyositis	M33.20		combined Immunodeficiencies		
Ordering Physician's Name		☐ Relapsing Remitting Multiple Sclerosis (RRMS) G		☐ Other Common Variable Immunodeficiencies		D83.9 L12.0	
		☐ Stiff Person Syndrome Other:	G25.82	☐ Pemphigoid ☐ Pemphigus		L12.0	
			604.01		<u> </u>		D81.2
Address		☐ Autoimmune Encephalopathy ☐ Idiopathic Thrombocytopenic Purpura	G04.81 D69.3	☐ SCID with Low or Normal B-Cell Numbers ☐ SCID with Low T- and B- Cell Numbers			D81.1
		☐ Inflammatory Neuropathies	G61.89	☐ Selective deficiency of IgG Subclasses		D80.3	
City, State, Zip		El milaminator y recuropatines	G01.09		c Antibody Deficiency		D80.6
only, olate, Lip					nic lupus erythematosus (SLE)		M32.9
Phone	Fax	Please Draw: □ CBC/diff □ CMP □ IgG w/subclasses 1- □ □ Frequency:	PER Anaphylaxis Protocol: Adult – EpiPen 0.3 auto-injector dual pack Pediatric – EpiPen 0.15 auto-injector dual pack Administer intramuscularly in the event of ADR* [May repeat x 1. Order is valid for 1 year]. **Use generic if applicable**				
Please fax the following i	information:			[Iviay repeat	x 1. Order is valid for 1 year]. Use	generic ii applicab	ie
□ History and Physical □ Pertinent Lab Work		Notes:	If applicable, flush intravenous access device per KabaFusion protoc			n protocol:	
□ Front & Back copy(s) of patient's insurance card(s)			Access		NS	Heparin	
1,511	• •		Periphera		1-3ml before/after use		after last NS flush
I authorize KabaFusion and its representatives to act as an agent and initiate and execute any insurance prior authorization process for this prescription, and any future			Midline, central (non-port), PICC 10ml		NS 5-10 mls before/after use; 10mls after blood draw	10 u/ml 3-5mls after last NS flush; 5mls after blood draw	
fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to KabaFusion.			Implanted Port		5-10mls before/after use; 20mls after blood draw	100 u/ml 5mls after last NS flush; 5mls after blood draw	
Physician Signature:			Tunneled Midling		5-10mls before/after use; 20mls after blood draw 5-10mls before/after use; 10mls	flush. 5mls after blood draw	

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