

Physician Signature:\_\_\_\_

## Immunoglobulin Prescription Form Please fax completed order form to 334.279.7032

241 Winton M. Blount Loop, Montgomery, Al. 36117

OFFICE: 800.814.0992   F	AX: 334.279.7032	<u>Prescription:</u>					
Demographic Information:		☐ Intravenous Immunoglobulin ☐ Subcutaneous Immunoglobulin					
<u>Demographic Informa</u>	<u> </u>	□ 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 OR mls  Other: sites time(s) per w					
Home Address		Hydration order:mls NS iv Pre-medications: Acetaminophen 650mg PO 30 Diphenhydramine 25mg PO 3	mins prior to infusior	n 🗆 Oth	for er Pre-medications:		
City, State, Zip		Diplomifydianinic 25mg 1 0 50	o mino prior to imasio	''			
Home Phone	ome Phone Mobile or Work Phone Clinical Information:  Patient Weight: Height: Allergies:						
Primary Insurance Name		□ IV access [for IVIg patients only]: _			se to place PIV prior to the		
Primary Insurance ID	Primary Insurance Group	Diagnosis	ICD-10	Diagr	nosis	ICD-10	
		Neuromuscular:			e Deficiency:		
Insured Name	Insured Date of Birth	☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	) G61.81	□ CVID v	w/ Predominant Immunoregulatory T-0	Cell Disorders D83.1	
		□ Dermatopolymyositis	M33.90		ned Immunodeficiency, Unspecified	D81.9 cified D83.9	
	<del></del>	☐ Guillain-Barre Syndrome (GBS)	G61.0		☐ Common Variable Immunodeficiency, Unspecified		
Secondary Insurance Name	Insurance ID Insurance Group	☐ Multifocal Motor Neuropathy	G61.82	_	tary 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		milial Hypogammaglobulinemia	D80.1 D81.89	
		□ Polymyositis	M33.20		combined Immunodeficiencies  Common Variable Immunodeficiencies	D81.89	
Ordering Physician's Name		☐ Relapsing Remitting Multiple Sclerosis (RRMS) ☐ Stiff Person Syndrome	G35 G25.82		□ Pemphigoid		
ordering rinjoidian situation		Other:	G25.62	□ Pemph	-	L12.0 L10.9	
		☐ Autoimmune Encephalopathy	G04.81		with Low or Normal B-Cell Numbers	D81.2	
Address		☐ Idiopathic Thrombocytopenic Purpura	D69.3 SCID with Low T- and B- Cell Numbers		D81.1		
		☐ Inflammatory Neuropathies	G61.89	☐ Selecti	ive deficiency of IgG Subclasses	D80.3	
City, State, Zip				☐ Specifi	c Antibody Deficiency	D80.6	
				☐ Systen	nic lupus erythematosus (SLE)	M32.9	
Phone	Fax	Please Draw:  PER Anaphylaxis Protocol:  □ Adult – EpiPen 0.3 auto-injector dual pack					
NPI		☐ CBC/diff ☐ CMP ☐ IgG w/subclasses 1-	-4 🗆 Quant. Ig		- EpiPen 0.15 auto-injector dual pack intramuscularly in the event of ADR*		
Please fax the following	information:	□ □ Frequency:		[May repeat	x 1. Order is valid for 1 year]. **Use	generic if applicable**	
☐ History and Physical ☐ Pertinent Lab Work		Notes:	If applicable, flush intravenous access device per KabaFusion protocol:			er KabaFusion protocol:	
☐ Front & Back copy(s) of patient's insurance card(s)			Access Peripheral		NS 1-3ml before/after use	Heparin 10u/ml 1-2mls after last NS flush	
authorize KabaFusion and its representatives to act as an agent and initiate and		1			NS 5-10 mls before/after use;	10 u/ml 3-5mls after last NS	
execute any insurance prior authorization process for this prescription, and any future			Midline, central (non-port), PICC		10mls after blood draw	flush; 5mls after blood draw	
fills of the same prescription for the patient listed above. I understand that I can			Implanted Port		5-10mls before/after use; 20mls after blood draw	100 u/ml 5mls after last NS flush; 5mls after blood draw	
revoke this designation at any time by providing written notice to KabaFusion.			Tunnolod		5-10mls before/after use; 20mls	10 u/ml 3- mls after last NS	

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Tunneled

Groshong PICC, Midline

flush. 5mls after blood draw

NO Heparin needed

after blood draw

5-10mls before/after use; 10mls

after blood draw