

Physician Signature:\_

## Immunoglobulin Prescription Form Please fax completed order form to 479.973.4890

5-10mls before/after use; 20mls

after blood draw

5-10mls before/after use; 10mls

after blood draw

Tunneled

Groshong PICC, Midline

10 u/ml 3- mls after last NS

flush. 5mls after blood draw

NO Heparin needed

3727 N Investment Drive | Favetteville. AR 72703

OFFICE: 866.263.2770   F	AX: 479.973.4890	<u>Prescription:</u>				
Demographic Information:		☐ Intravenous Immunoglobulin ☐ Subcutaneous Immunoglobulin				
Demographic Informa	mon.	□ 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  □ Other: sites				
Home Address		Hydration order:mls NS iv  Pre-medications: Acetaminophen 650mg PO 30 or  Diphenhydramine 25mg PO 30	mins prior to infusion	□ Oth	for er Pre-medications:	
City, State, Zip			Thins prior to infusion			
Home 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 thera	
Primary Insurance ID	Primary Insurance Group	Diagnosis	ICD-10	Diagr	nosis	ICD-10
		Neuromuscular:			Deficiency:	
Insured Name	Insured Date of Birth	☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	G61.81	□ CVID \	v/ Predominant Immunoregulatory T-Cell	
		□ Dermatopolymyositis	M33.90 G61.0		ned Immunodeficiency, Unspecified	D81.9
Consideration Income Name		☐ Guillain-Barre Syndrome (GBS)			□ Common Variable Immunodeficiency, Unspecified D83.9	
Secondary Insurance Name	Insurance ID Insurance Group	☐ Multifocal Motor Neuropathy	G61.82		tary Hypogammaglobulinemia	D80.0
	<u> </u>	☐ Myasthenia Gravis (MG)	G70.0		nodeficiency with Increased IgM	D80.5 D80.1
Secondary Insurance ID	Secondary Insurance Group	☐ Myasthenia Gravis with (Acute) Exacerbation ☐ Polymyositis	G70.01 M33.20	□ Nonfamilial Hypogammaglobulinemia □ Other combined Immunodeficiencies		D81.89
		□ Relapsing Remitting Multiple Sclerosis (RRMS)	G35		Common Variable Immunodeficiencies	D83.9
Ordering Physician's Name		☐ Stiff Person Syndrome	G25.82  Pemphigoid		L12.0	
		Other:		□ Pemph		L10.9
Address		☐ Autoimmune Encephalopathy	G04.81	□ SCID v	vith Low or Normal B-Cell Numbers	D81.2
Audicoo		☐ Idiopathic Thrombocytopenic Purpura	D69.3 ☐ SCID with Low T- and B- Cell Numbers		D81.1	
		☐ Inflammatory Neuropathies	G61.89		ve deficiency of IgG Subclasses	D80.3
City, State, Zip			☐ Specific 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 □ Pediatric - EpiPen 0.15 auto-injector dual pack				
Please fax the following	information:	□ □ Frequency:		[May repeat	x 1. Order is valid for 1 year]. **Use ger	neric if applicable**
☐ History and Physical ☐ Pertinent Lab Work		Notes:	If applicable, flush intravenous access device per KabaFusion protocol:			
☐ Front & Back copy(s) of patient's insurance card(s)					NS 1. 2ml hoforo/offer use	Heparin
Lauthorize KahaEucion and its correspondatives to get as an agent and initiate and		<b>1</b>	Peripheral 1-3ml before/after use  NS 5-10 mls before/after use;		10u/ml 1-2mls after last NS flush 10 u/ml 3-5mls after last NS	
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			10mls after blood draw flush; 5		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 5-10mls before/after use; 20mls		100 u/ml 5mls after last NS flush; 5mls after blood draw	

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