KabaFusion
Patient-Focused Infusion Therapy

3500 NW Boca Raton Blvd, Ste 704, Boca Raton, FL 33431
OFFICE: 877.309.2207 | FAX: 877.309.2209

Immunoglobulin Prescription Form

Please fax completed order form to 877.309.2209

Demographic Information:

Patient Name _____ **Date of Birth** _____

Home Address _____

City, State, Zip _____

Home Phone _____ **Mobile or Work Phone** _____

Primary Insurance Name _____

Primary Insurance ID _____ **Primary Insurance Group** _____

Insured Name _____ **Insured Date of Birth** _____

Secondary Insurance Name _____ **Insurance ID** _____ **Insurance Group** _____

Secondary Insurance ID _____ **Secondary Insurance Group** _____

Ordering Physician's Name _____

Address _____

City, State, Zip _____

Phone _____ **Fax** _____

NPI _____

Please fax the following information:

□ History and Physical □ Pertinent Lab Work
□ Front & Back copy(s) of patient's insurance card(s)

Physician Signature: _____

Date: _____

Prescription:

☐ **Intravenous Immunoglobulin** ☐ **Subcutaneous Immunoglobulin**

☐ 0.4 gm/kg ☐ 1gm/kg ☐ 2gm/kg ☐ _____ grams

Infuse: ☐ IV daily x _____ day(s); repeat every _____ week(s) x _____ cycles Infuse _____ grams OR _____ mls

☐ Other: _____ using _____ sites _____ time(s) per week

Hydration order: _____ mls NS iv to be infused prior/post IVIG. for _____ months.

☐ Pre-medications: Acetaminophen 650mg PO 30 mins prior to infusion ☐ Other Pre-medications: _____
Diphenhydramine 25mg PO 30 mins prior to infusion

Clinical Information:

Patient Weight: _____ Height: _____ Allergies: _____

☐ IV access [for IVIg patients only]: _____ ☐ Nurse to place PIV prior to therapy

Diagnosis	ICD-10	Diagnosis	ICD-10
Neuromuscular:		**Immune Deficiency:**	
☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	G61.81	☐ CVID w/ Predominant Immunoregulatory T-Cell Disorders	D83.1
☐ Dermatopolymyositis	M33.90	☐ Combined Immunodeficiency, Unspecified	D81.9
☐ Guillain-Barre Syndrome (GBS)	G61.0	☐ Common Variable Immunodeficiency, Unspecified	D83.9
☐ Multifocal Motor Neuropathy	G61.82	☐ Hereditary Hypogammaglobulinemia	D80.0
☐ Myasthenia Gravis (MG)	G70.0	☐ Immunodeficiency with Increased IgM	D80.5
☐ Myasthenia Gravis with (Acute) Exacerbation	G70.01	☐ Nonfamilial Hypogammaglobulinemia	D80.1
☐ Polymyositis	M33.20	☐ Other combined Immunodeficiencies	D81.89
☐ Relapsing Remitting Multiple Sclerosis (RRMS)	G35	☐ Other Common Variable Immunodeficiencies	D83.9
☐ Stiff Person Syndrome	G25.82	☐ Pemphigoid	L12.0
Other:		☐ Pemphigus	L10.9
☐ Autoimmune Encephalopathy	G04.81	☐ SCID with Low or Normal B-Cell Numbers	D81.2
☐ Idiopathic Thrombocytopenic Purpura	D69.3	☐ SCID with Low T- and B- Cell Numbers	D81.1
☐ Inflammatory Neuropathies	G61.89	☐ Selective deficiency of IgG Subclasses	D80.3
		☐ Specific Antibody Deficiency	D80.6
		☐ Systemic lupus erythematosus (SLE)	M32.9

Please Draw:

□ CBC/diff □ CMP □ IgG w/subclasses 1-4 □ Quant. Ig
☐ _____ ☐ _____ 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**

Notes:

If applicable, flush intravenous access device per KabaFusion protocol:

Access	NS	Heparin
Peripheral	1-3ml before/after use	10u/ml 1-2mls after last NS flush
Midline, central (non-port), PICC	NS 5-10 mls before/after use; 10mls after blood draw	10 u/ml 3-5mls after last NS flush; 5mls after blood draw
Implanted Port	5-10mls before/after use; 20mls after blood draw	100 u/ml 5mls after last NS flush; 5mls after blood draw
Tunneled	5-10mls before/after use; 20mls after blood draw	10 u/ml 3- mls after last NS flush. 5mls after blood draw
Groshong PICC, Midline	5-10mls before/after use; 10mls after blood draw	NO Heparin needed