

Immunoglobulin Prescription Form Please fax completed order form to 877.309.2209

after blood draw

3500 NW Boca Raton Blvd, Ste 704, Boca Raton, FL 33431

OFFICE: 877.309.2207 I	FAX: 877.309.2209	<u>Prescription:</u>					
Demographic Information:		☐ Intravenous Immunoglobulin ☐ Subcutaneous Immunoglobulin					
Demographic Informa	<u>ation:</u>	□ 0.4 gm/kg □1gm/kg □2gm/kg □	grams				
Dationt Name	Date of Birth	Infuse: ☐ IV daily x day(s); repeat every		cycles	Infuse grams (OR mls	;
Patient Name Date of Birth		Other: using sites time(s) per we					
Hanna Addanaa		Hydration order:mls NS iv		oost IVIC	for		(3) per week
Home Address		□ Pre-medications: Acetaminophen 650mg PO 30					
0:1 0:1 7:		Diphenhydramine 25mg PO 30			TTTE-medications.		
City, State, Zip							
		<u>Clinical Information:</u>					
Home Phone	Mobile or Work Phone						
		Patient Weight: Height:		Allergies: _			
Primary Insurance Name		□ IV access [for IVIg patients only]:		□ Nurs	e to place PIV prior to the	rapy	
Primary Insurance ID	Primary Insurance Group	Diagnosis	ICD-10	Diagn	nsis		ICD-10
•		Neuromuscular:	102 10		Deficiency:		102 10
Insured Name	Insured Date of Birth	☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	G61.81	B1 CVID w/ Predominant Immunoregulatory T-Cell Disorder		ell Disorders	D83.1
moured runne	modred bate of birth	☐ Dermatopolymyositis	M33.90	☐ Combin	ed Immunodeficiency, Unspecified		D81.9
		☐ Guillain-Barre Syndrome (GBS)	G61.0	☐ Common Variable Immunodeficiency, Unspecified		fied	D83.9
Secondary Insurance Name	Insurance ID Insurance Group	☐ Multifocal Motor Neuropathy	G61.82		ary Hypogammaglobulinemia		D80.0
		☐ Myasthenia Gravis (MG)	G70.0		odeficiency with Increased IgM		D80.5
Secondary Insurance ID Secondary Insurance G		☐ Myasthenia Gravis with (Acute) Exacerbation	G70.01		□ Nonfamilial Hypogammaglobulinemia		D80.1
		□ Polymyositis	M33.20		ombined Immunodeficiencies		D81.89
Ordering Physician's Name		☐ Relapsing Remitting Multiple Sclerosis (RRMS)		G35			D83.9
		☐ Stiff Person Syndrome Other:	G25.82	☐ Pemphigoid ☐ Pemphigus			L12.0 L10.9
			G04.81		<u> </u>		D81.2
Address				☐ SCID with Low or Normal B-Cell Numbers ☐ SCID with Low T- and B- Cell Numbers			D81.1
		☐ Inflammatory Neuropathies	D69.3 G61.89		re deficiency of IgG Subclasses		D80.3
City, State, Zip		E milanimatory recuropatities	G01.09		Antibody Deficiency		D80.6
only, orace, hip					ic lupus erythematosus (SLE)		M32.9
				.,			
Phone	Fax	Please Draw:		PER Ana	ohylaxis Protocol:		
					Pen 0.3 auto-injector dual pack		
NPI		☐ CBC/diff ☐ CMP ☐ IgG w/subclasses 1-4			c – EpiPen 0.15 auto-injector dual pack		
Please fax the following	information:	□ □ Frequency: _			ntramuscularly in the event of ADR* 1. Order is valid for 1 year]. **Use of	generic if applicabl	e**
_		Notes:	If applicable	flush intr	avenous access device pe	r KahaFusio	n protocol:
□ History and Physical □	□ Pertinent Lab Work	Notes.	тт аррисавте	, musii iiiti	averious access device pe	i Kabai usio	ii protocoi.
□ Front & Back copy(s) of patient's insurance card(s)			Access NS		NS	Heparin	
		4	Periphera	l	1-3ml before/after use		after last NS flush
			Midline, central (non-port), PICC Implanted Port Tunneled		NS 5-10 mls before/after use; 10mls after blood draw	10 u/ml 3-5mls after last NS flush; 5mls after blood draw	
Physician Signature:					5-10mls before/after use; 20mls after blood draw		nls after last NS ifter blood draw
		[]			5-10mls before/after use; 20mls	10 u/ml 3- m	nls after last NS
]			after blood draw 5-10mls before/after use; 10mls	flush. 5mls a	fter blood draw
Date:			Groshong PICC,	Midline	5-Turnis berore/arter use; Turnis	NO Hepa	arin needed

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