

Physician Signature:_

Immunoglobulin Prescription Form Please fax completed order form to 773.775.2732

5-10mls before/after use; 10mls

after blood draw

NO Heparin needed

Groshong PICC, Midline

5517 N. Cumberland Ave | Suite 915 | Chicago, IL 60656

OFFICE: 800.831.7740 FAX: 773.775.2732							
Demographic Information:		☐ Intravenous Immunoglobulin ☐ Subcutaneous Immunoglobulin					
Demographic Informa	, , , , , , , , , , , , , , , , , , ,	□ 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	5
ration manie	24.0 0. 2	□ Other:			using sites		
Home Address		Hydration order:mls NS iv		nost IVIG.	for		(6) [-3
nome Address		□ Pre-medications: Acetaminophen 650mg PO 30					
		Diphenhydramine 25mg PO 30	•		El Fre-medications.		
City, State, Zip		- P	2 mine prop 1.				
		Clinical Information:					
Home Phone							
		Patient Weight: Height: Allergies:					
Primary Insurance Name							
-		□ IV access [for IVIg patients only]:		□ Nurs	se to place PIV prior to the	erapy	
Primary Insurance ID Primary Insurance Group		Diagnosis	ICD-10	Diagnosis			ICD-10
		Neuromuscular:	100-10	Immune Deficiency:			100-10
		☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	P) G61.81		☐ CVID w/ Predominant Immunoregulatory T-Cell Disorders		D83.1
Insured Name	Insured Date of Birth	☐ Dermatopolymyositis	M33.90		ned Immunodeficiency, Unspecified		D81.9
		☐ Guillain-Barre Syndrome (GBS)	G61.0		on Variable Immunodeficiency, Unspec	ified	D83.9
Secondary Insurance Name Insurance ID Insurance Group		☐ Multifocal Motor Neuropathy	G61.82	☐ Hereditary Hypogammaglobulinemia			D80.0
		☐ Myasthenia Gravis (MG)	G70.0	□ Immur	nodeficiency with Increased IgM		D80.5
Secondary Insurance ID	Secondary Insurance Group	☐ Myasthenia Gravis with (Acute) Exacerbation	G70.01	☐ Nonfan	familial Hypogammaglobulinemia		D80.1
Secondary Insurance 15 Secondary Insurance Group		□ Polymyositis	M33.20	□ Other o	☐ Other combined Immunodeficiencies		
		☐ Relapsing Remitting Multiple Sclerosis (RRMS)	G35	☐ Other Common Variable Immunodeficiencies			D83.9
Ordering Physician's Name		☐ Stiff Person Syndrome	Stiff Person Syndrome G25.82		☐ Pemphigoid		L12.0
		Other:		☐ Pemphigus			L10.9
Address		☐ Autoimmune Encephalopathy	G04.81	□ SCID w	☐ SCID with Low or Normal B-Cell Numbers		D81.2
Audress		☐ Idiopathic Thrombocytopenic Purpura	D69.3	☐ SCID with Low T- and B- Cell Numbers			D81.1
		☐ Inflammatory Neuropathies	G61.89	☐ Selectiv	ve deficiency of IgG Subclasses		D80.3
City, State, Zip				☐ Specific	c Antibody Deficiency		D80.6
			☐ Systemic I		nic lupus erythematosus (SLE)		M32.9
Phone	Fax						
Prione Fax		Please Draw:		PER Anaphylaxis Protocol:			
		= CDC/diff = CMD = IgC w/cubclasses 1	4 - Ouant Id		piPen 0.3 auto-injector dual pack		
NPI		□ CBC/diff □ CMP □ IgG w/subclasses 1-	·4 🗆 Quant. 19		- EpiPen 0.15 auto-injector dual pack intramuscularly in the event of ADR*		
Please fax the following information:		□ □ Frequency:			x 1. Order is valid for 1 year]. **Use	generic if applicab	le**
•		Notes:	If applicable, flush intravenous access device per KabaFusion protocol:				
☐ History and Physical ☐ Pertinent Lab Work							-
□ Front & Back copy(s) of patient's insurance card(s)			Access		NS	Heparin	
		4	Periphera	<u> 1</u>	1-3ml before/after use		after last NS flush
authorize KabaFusion and its representatives to act as an agent and initiate and			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	
execute any insurance prior authorization process for this prescription, and any future fills of the same prescription for the patient listed above. I understand that I can			Implanted Port		5-10mls before/after use; 20mls	100 u/ml 5mls after last NS	
revoke this designation at any time by providing written notice to KabaFusion.			<u>'</u>		after blood draw 5-10mls before/after use; 20mls		after blood draw nls after last NS
,	,,		Tunneled		after blood draw		ofter blood draw

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