

159 Memorial Drive | Unit E | Shrewsbury, MA 01545 Prescription: OFFICE: 888.727.2323 | FAX: 888.966.0416 □ Intravenous Immunoglobulin □ Subcutaneous Immunoglobulin Demographic Information: □ 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 Patient Name Date of Birth Other: using ______ sites ______ time(s) per week Hydration order: _____mls NS iv to be infused prior/post IVIG. for_____months. Home Address Pre-medications: Acetaminophen 650mg PO 30 mins prior to infusion Other Pre-medications: ______ Diphenhydramine 25mg PO 30 mins prior to infusion City, State, Zip Clinical Information: Home Phone Mobile or Work Phone Patient Weight: _____ Height: _____ Allergies: Primary Insurance Name IV access [for IVIg patients only]: _____ Nurse to place PIV prior to therapy Primary Insurance ID Primary Insurance Group ICD-10 Diagnosis ICD-10 Diagnosis Immune Deficiency: Neuromuscular: Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) CVID w/ Predominant Immunoregulatory T-Cell Disorders D83.1 G61.81 Insured Name **Insured Date of Birth** Dermatopolymyositis Combined Immunodeficiency, Unspecified D81.9 M33 90 □ Guillain-Barre Syndrome (GBS) Common Variable Immunodeficiency, Unspecified D83.9 G61.0 Secondary Insurance Name Insurance ID Insurance Group D80.0 Multifocal Motor Neuropathy G61.82 Hereditary Hypogammaglobulinemia D80 5 □ Myasthenia Gravis (MG) □ Immunodeficiency with Increased IgM G70.0 D80 1 □ Myasthenia Gravis with (Acute) Exacerbation G70.01 Nonfamilial Hypogammaglobulinemia Secondary Insurance ID Secondary Insurance Group D81.89 □ Polymyositis M33.20 □ Other combined Immunodeficiencies Relapsing Remitting Multiple Sclerosis (RRMS) Other Common Variable Immunodeficiencies D83.9 G35 Ordering Physician's Name □ Stiff Person Syndrome L12.0 G25.82 Pemphigoid L10.9 Other: Pemphigus SCID with Low or Normal B-Cell Numbers D81.2 □ Autoimmune Encephalopathy G04.81 Address □ Idiopathic Thrombocytopenic Purpura D69.3 □ SCID with Low T- and B- Cell Numbers D81.1 □ Inflammatory Neuropathies D80.3 □ Selective deficiency of IgG Subclasses G61.89 City, State, Zip D80.6 □ Specific Antibody Deficiency M32.9 □ Systemic lupus erythematosus (SLE) Phone Fax PER Anaphylaxis Protocol: Please Draw: □ Adult – EpiPen 0.3 auto-injector dual pack □ CBC/diff □ CMP □ IgG w/subclasses 1-4 □ Quant. Ig NPI Pediatric – EpiPen 0.15 auto-injector dual pack * Administer intramuscularly in the event of ADR* □ □ □ Frequency: [May repeat x 1. Order is valid for 1 year]. **Use generic if applicable** Please fax the following information: 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 Peripheral 1-3ml before/after use 10u/ml 1-2mls after last NS flush 10 u/ml 3-5mls after last NS NS 5-10 mls before/after use: I authorize KabaFusion and its representatives to act as an agent and initiate and Midline, central (non-port), PICC flush; 5mls after blood draw 10mls after blood draw execute any insurance prior authorization process for this prescription, and any future 5-10mls before/after use; 20mls 100 u/ml 5mls after last NS Implanted Port fills of the same prescription for the patient listed above. I understand that I can flush: 5mls after blood draw after blood draw revoke this designation at any time by providing written notice to KabaFusion. 10 u/ml 3- mls after last NS 5-10mls before/after use; 20mls Tunneled after blood draw flush. 5mls after blood draw Physician Signature:_____ 5-10mls before/after use; 10mls Groshong PICC, Midline NO Heparin needed after blood draw Date:

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Immunoglobulin Prescription Form

Please fax completed order form to 888.966.0416