

Date:

## Immunoglobulin Prescription Form Please fax completed order form to 616.554.6171

after blood draw

NO Heparin needed

Groshong PICC, Midline

3631 44th Street SE I Suite C I Kentwood MI 49512

OFFICE: 616.554.3530   F.	AX: 616.554.6171	<u>Prescription:</u>					
·		☐ Intravenous Immunoglobulin ☐ Subcutaneous Immunoglobul					ulin
<u>Demographic Information:</u>		□ 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		
		□ Other:			using sites	time	(s) per week
Home Address		Hydration order:mls NS iv	to be infused prior/po	st IVIG.	for	_months.	
		□ Pre-medications: Acetaminophen 650mg PO 30 i			er Pre-medications:		
City, State, Zip		Diphenhydramine 25mg PO 30	mins prior to infusior	l			
,		04 4 44 6 44					
Home Phone	Mobile or Work Phone	<u>Clinical Information:</u>					
		Patient Weight: Height: Allergies:					
Drimary Incurance Name		Tatione weights Heights					
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:	102 10		Deficiency:		102 10
Insured Name	Insured Date of Birth	☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	G61.81	□ CVID v	CVID w/ Predominant Immunoregulatory T-Cell Disorders		D83.1
msured reame	msured bate of birth	□ Dermatopolymyositis	M33.90	☐ Combi	ned Immunodeficiency, Unspecified		D81.9
		☐ Guillain-Barre Syndrome (GBS)	G61.0	□ Comm	on Variable Immunodeficiency, Unspec	D83.9	
Secondary Insurance Name	Insurance ID Insurance Group	☐ Multifocal Motor Neuropathy	G61.82		tary 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		☐ Nonfamilial Hypogammaglobulinemia		D80.1
,	, , , , , , , , , , , , , , , , , , , ,	□ Polymyositis	M33.20		combined Immunodeficiencies		D81.89
		☐ Relapsing Remitting Multiple Sclerosis (RRMS)	G35	_	Common Variable Immunodeficiencies		D83.9
Ordering Physician's Name		☐ Stiff Person Syndrome	G25.82				L12.0
		Other:		□ Pemph			L10.9
Address		☐ 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 D80.3	
City, State, Zip		☐ Inflammatory Neuropathies	G61.89		ve deficiency of IgG Subclasses c Antibody Deficiency		D80.6
City, State, Zip					nic lupus erythematosus (SLE)		M32.9
				□ System	iic lupus crythematosus (SEE)		
Phone	Fax	Diagon Dunius		DFD Δna	phylaxis Protocol:		
		Please Draw:			priylaxis i rotocor. piPen 0.3 auto-injector dual pack		
NPI		☐ CBC/diff ☐ CMP ☐ IgG w/subclasses 1-4 ☐ Quai			ediatric – EpiPen 0.15 auto-injector dual pack		
		_	_	* Administer	intramuscularly in the event of ADR*	, ., .	
Please fax the following i	information:	□ □ Frequency:		[May repeat	x 1. Order is valid for 1 year]. **Use	generic if applicab	ie^^
□ History and Physical □	Pertinent Lah Work	Notes:	If applicable,	flush inti	ravenous access device pe	r KabaFusio	n protocol:
□ History and Physical □ Pertinent Lab Work					N.C.	Horavia	
□ Front & Back copy(s) of patient's insurance card(s)			Access Peripheral		NS 1-3ml before/after use	Heparin 10u/ml 1-2mls after last NS flush	
Lauthoriza KahaEusian and its representatives to act as an agent and initiate and		<b> </b>	Midline, central (non-port), PICC  Implanted Port  Tunneled		NS 5-10 mls before/after use;	10u/mi 1-2mis 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; 5mls after blood draw	
fills of the same prescription for the patient listed above. I understand that I can					5-10mls before/after use; 20mls after blood draw	100 u/ml 5mls after last NS flush: 5mls after blood draw	
revoke this designation at any time by providing written notice to KabaFusion.					5-10mls before/after use; 20mls	10 u/ml 3- n	nls after last NS
Physician Signature:		[	Construe BICC Midling		after blood draw 5-10mls before/after use; 10mls	flush. 5mls after blood draw	

CONFIDENTIALITY NOTICE: The following includes confidential, proprietary information that is the sole exclusive property of KabaFusion, LLC. No rights in, relating to, or derived from such information are assigned or otherwise transferred by this document, and the recipient of such information is subject to obligations of secrecy to and for the benefit of KabaFusion, LLC. Any unauthorized use or disclosure of such information is strictly prohibited. This message, together with any attachments, is intended only for the use of the individual or entity to which it is addressed and may contain information that is confidential and prohibited from disclosure. If you are not the intended recipient, you are hereby notified that any dissemination, or copying of this message, or any attachment, is strictly prohibited. If you have received this message in error, please notify the original sender immediately by telephone or by return fax and shred this document along with any other documents. Thank you.