

Immunoglobulin Prescription Form Please fax completed order form to 800.915.3423

after blood draw

NO Heparin needed

Groshong PICC, Midline

160 Raritan Center Parkway | Suite 18 | Edison, NJ 08837

| OFFICE: 800.383.8393 F | FAX: 800.915.3423 | <u>Prescription:</u> | | | | | |
|--|-----------------------|--|---|---|--|--|---------------------|
| Demographic Information: | | ☐ Intravenous Immunoglobulin ☐ Subcutaneous Immunoglobulin | | | | | |
| <u>Demographic Informa</u> | <u> </u> | □ 0.4 gm/kg □1gm/kg □2gm/kg □ | grams | | | | |
| Patient Name Date of Birth | | Infuse: ☐ IV daily x day(s); repeat every ☐ Other: | week(s) x | cycles | Infuse grams using sites | | |
| Home Address | | Hydration order:mls NS iv to be infused prior/post IVIG. formonths. □ Pre-medications: Acetaminophen 650mg PO 30 mins prior to infusion □ Other Pre-medications: Diphenhydramine 25mg PO 30 mins prior to infusion | | | | | |
| City, State, Zip | | Dipnennyaramine 25mg PO 30 | mins prior to iniusio | 11 | | | |
| Home Phone | Mobile or Work Phone | Clinical Information: Patient Weight: Allergies: | | | | | |
| Primary Insurance Name | | □ IV access [for IVIg patients only]: | | □ Nur | se to place PIV prior to the | erapy | |
| Primary Insurance Group Primary Insurance Group | | Diagnosis | | Diagr | Diagnosis | | ICD-10 |
| | | Neuromuscular: | | Immune | Deficiency: | | |
| Insured Name | Insured Date of Birth | ☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) | G61.81 | □ CVID v | ☐ CVID w/ Predominant Immunoregulatory T-Cell Disorders | | D83.1 |
| | | ☐ Dermatopolymyositis | M33.90 | | ned Immunodeficiency, Unspecified | | D81.9 |
| Secondary Insurance Name Insurance ID Insurance Group | | ☐ Guillain-Barre Syndrome (GBS) | G61.0 | | on Variable Immunodeficiency, Unspec | ified | D83.9 |
| | | ☐ Multifocal Motor Neuropathy | G61.82 | | Hereditary Hypogammaglobulinemia | | D80.0 |
| | | ☐ Myasthenia Gravis (MG) | G70.0 | | 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 D83.9 |
| Ordering Physician's Name | | ☐ Relapsing Remitting Multiple Sclerosis (RRMS) | | | Other Common Variable Immunodeficiencies | | L12.0 |
| | | ☐ Stiff Person Syndrome Other: | G25.82 | ☐ Pemphigoid ☐ Pemphigus | | L10.9 | |
| | | ☐ Autoimmune Encephalopathy | G04.81 | | <u> </u> | | D81.2 |
| Address | | ☐ Idiopathic Thrombocytopenic Purpura | D69.3 | ☐ SCID with Low or Normal B-Cell Numbers ☐ SCID with Low T- and B- Cell Numbers | | | D81.1 |
| | | ☐ Inflammatory Neuropathies | G61.89 | ☐ Selective deficiency of IgG Subclasses | | D80.3 | |
| City, State, Zip | | 2 millimatory neuropatines | G01.07 | | c Antibody Deficiency | | D80.6 |
| only, oraco, z.p | | | | | nic lupus erythematosus (SLE) | | M32.9 |
| Phone | Fax | Please Draw: □ CBC/diff □ CMP □ IgG w/subclasses 1- | 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* | | | | |
| Please fax the following | information: | □ □ Frequency: | | [May repeat | x 1. Order is valid for 1 year]. **Use | generic if applicabl | e** |
| □ History and Physical □ Pertinent Lab Work | | Notes: | If applicable, flush intravenous access device per KabaFusion protocol: | | | | |
| □ Front & Back copy(s) of patient's insurance card(s) | | | Access | | NS | Heparin | |
| 1307 | . , | | Peripheral | | 1-3ml before/after use | 10u/ml 1-2mls | after last NS flush |
| 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 a | | NS 5-10 mls before/after use; 10mls after blood draw | 10 u/ml 3-5mls after last NS flush; 5mls after blood draw | |
| fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to KabaFusion. | | | Implanted Port | | 5-10mls before/after use; 20mls after blood draw | flush; 5mls after blood draw | |
| Physician Signature: | | | Tunneled Construction PLOS Mid-line | | 5-10mls before/after use; 20mls after blood draw 5-10mls before/after use; 10mls | flush. 5mls after blood draw | |

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