

Immunoglobulin Prescription Form Please fax completed order form to 518.862.1400

after blood draw

57 Karner Road L Suite B L Albany, NY 12205

Date: _

OFFICE: 518690.1060 FAX: 518.862.1400		<u>Prescription:</u>					
Demographic Information:		☐ Intravenous Immunoglobulin ☐ Subcutaneous Immunoglobulin					
Demograpine Informa	<u>attom.</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	OR mls	
		□ Other:	,		using sites	time(s) per week	
Home Address		Hydration order:mls NS iv to be infused prior/post IVIG. formonths.					
		□ Pre-medications: Acetaminophen 650mg PO 30			er Pre-medications:		
City, State, Zip		Diphenhydramine 25mg PO 30) mins prior to infus	on			
		Clinical Information:					
Home Phone Mobile or Work Phone		<u>omnear miormation.</u>					
		Patient Weight: Height: Allergies:					
Primary Insurance Name		N/ F6 N/I II I I I					
		IV access [for IVIg patients only]:			se to place PIV prior to the	яару	
Primary Insurance ID	Primary Insurance Group	Diagnosis	ICD-1	Diagr	nosis	ICD-10	
		Neuromuscular:		Immun	e Deficiency:		
Insured Name	Insured Date of Birth	☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)) G61.81	□ CVID :	w/ Predominant Immunoregulatory T-C		
		☐ Dermatopolymyositis	M33.90		ned Immunodeficiency, Unspecified	D81.9	
		☐ Guillain-Barre Syndrome (GBS)	G61.0		on Variable Immunodeficiency, Unspec		
Secondary Insurance Name	Insurance ID Insurance Group	☐ Multifocal Motor Neuropathy	G61.82		itary 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			milial Hypogammaglobulinemia	D80.1	
		□ Polymyositis	M33.20		combined Immunodeficiencies	D81.89	
Ordering Physician's Name		☐ Relapsing Remitting Multiple Sclerosis (RRMS) ☐ Stiff Person Syndrome	G35		Common Variable Immunodeficiencies	L12.0	
ordering Physician's Name		Other:	G25.82		☐ Pemphigoid ☐ Pemphigus		
		☐ Autoimmune Encephalopathy	G04.81		with Low or Normal B-Cell Numbers	L10.9 D81.2	
Address		☐ Idiopathic Thrombocytopenic Purpura	D69.3		SCID with Low T- and B- Cell Numbers		
		☐ Inflammatory Neuropathies	G61.89		ive deficiency of IgG Subclasses	D81.1 D80.3	
City, State, Zip	-				ic Antibody Deficiency	D80.6	
•				☐ Syster	nic lupus erythematosus (SLE)	M32.9	
Phone	Fax						
Thone	I ux	Please Draw:		PER Anaphylaxis Protocol: Adult – EpiPen 0.3 auto-injector dual pack			
NPI		□ CBC/diff □ CMP □ IgG w/subclasses 1-	·4 □ Ouant. Ig		- EpiPen 0.15 auto-injector dual pack		
NPI		•	- Quantity	* 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 applicable**	
☐ History and Physical ☐	□ Pertinent Lab Work	Notes:	If applicable	e, flush int	ravenous access device pe	er KabaFusion protocol:	
□ 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	
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 lills of the same prescription for the patient listed above. I understand that I can			Implanted Port 5-10		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.			5 10mlc		after blood draw 5-10mls before/after use; 20mls	flush; 5mls after blood draw 10 u/ml 3- mls after last NS	
			Tunneled		after blood draw	flush. 5mls after blood draw	
Physician Signature:			Groshong PICC, Midline		5-10mls before/after use; 10mls	NO Heparin needed	

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