

**Physician Signature:** 

## Immunoglobulin Prescription Form Please fax completed order form to 757-424-5871

5-10mls before/after use; 10mls

after blood draw

NO Heparin needed

Groshong PICC, Midline

816 Greenbrier Cir. | Suite E | Chesapeake, VA 23320

OFFICE: 757.424.4822   FAX: 757.424.5871		<u>rrescription.</u>					
Demographic Information:		☐ Intravenous Immunoglobulin ☐ Subcutaneous Immunoglobulin					oulin
Demograpme imornie	<del></del>	□ 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:         sites time(s) per					
Home Address		Hydration order:mls NS iv	mins prior to infusio	n 🗆 Oth	for er Pre-medications:		
City, State, Zip		Diphenhydramine 25mg PO 30	Jimins prior to iniusi	UII			
Home Phone	Mobile or Work Phone	- <u>Clinical Information:</u> 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	) Diagr	Diagnosis		ICD-10
		Neuromuscular:		Immune	Immune Deficiency:		
Insured Name	Insured Date of Birth	☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	G61.81	□ CVID \	☐ CVID w/ Predominant Immunoregulatory T-Cell Disorders		D83.1
msured runne	modrou bate of birth	□ Dermatopolymyositis	M33.90	☐ Combi	ned Immunodeficiency, Unspecified		D81.9
		☐ Guillain-Barre Syndrome (GBS)	G61.0	☐ Comm	☐ Common Variable Immunodeficiency, Unspecified		
Secondary Insurance Name	Insurance ID Insurance Group	☐ Multifocal Motor Neuropathy	G61.82			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
Secondary Insurance ID	Secondary Insurance Group	□ Polymyositis	M33.20	☐ Other	combined Immunodeficiencies		D81.89
		☐ Relapsing Remitting Multiple Sclerosis (RRMS)	G35	☐ Other	Common Variable Immunodeficiencies		D83.9
Ordering Physician's Name		☐ Stiff Person Syndrome	G25.82		□ Pemphigoid		L12.0
0		Other:		□ Pemph	•		L10.9
		☐ Autoimmune Encephalopathy	G04.81		vith Low or Normal B-Cell Numbers		D81.2
Address		☐ Idiopathic Thrombocytopenic Purpura	D69.3	☐ SCID with Low T- and B- Cell Numbers			D81.1
		☐ Inflammatory Neuropathies		G61.89			D80.3
City, State, Zip	_				c Antibody Deficiency		D80.6
			☐ Systemic lupus erythematosus (SLE)			M32.9	
Phone	Fax	Please Draw: PER Anaphylaxis Protocol:					
		ODO/JUST CMD T.C. / I I	4 0 1 7		iPen 0.3 auto-injector dual pack		
NPI		☐ CBC/diff ☐ CMP ☐ IgG w/subclasses 1-	-4 🗆 Quant. 1g		c – EpiPen 0.15 auto-injector dual pack		
Please fax the following information:		□ □ Frequency:	[May repeat x		intramuscularly in the event of ADR* x 1. <b>Order is valid for 1 year</b> ]. **Use generic if applicable**		
☐ History and Physical ☐ Pertinent Lab Work		Notes:	If applicable, flush intravenous access device per KabaFusion protocol				on protocol:
□ Front & Back copy(s) of patient's insurance card(s)					1		
			Acces		NS	Heparin 10u/ml 1-2mls after last NS flush	
		-l	Peripher		1-3ml before/after use		
l 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 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.		1	Midline, central (non-port), PIC		NS 5-10 mls before/after use; 10mls after blood draw	10 u/ml 3-5mls after last NS flush; 5mls after blood draw	
			Implanted Port Tunneled		5-10mls before/after use; 20mls after blood draw	100 u/ml 5mls after last NS flush; 5mls after blood draw	
					5-10mls before/after use; 20mls		mls after last NS

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