

Physician Signature:_

Immunoglobulin Prescription Form Please fax completed order form to 877.445.8821

5-10mls before/after use; 10mls

after blood draw

NO Heparin needed

Groshong PICC, Midline

12450 E. Arapahoe Rd | Suite A-1 | Centennial, CO 80112 | Description:

OFFICE: 720.543.2321 FAX: 877.445.8821		<u>rrescription.</u>					
Demographic Information:		□ Intravenous Immunoglobulin □ Subcutaneous Immunoglobulin					ulin
<u> Demographic Informa</u>	tion.	□ 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	
ration Name	Date of Birth	□ Other:			using sites		
Home Address	_	Hydration order:mls NS iv		post IVIG.	for		. , ,
Home Address		□ Pre-medications: Acetaminophen 650mg PO 30					
City State 7in		Diphenhydramine 25mg PO 30					
City, State, Zip							
		<u>Clinical Information:</u>					
Home Phone Mobile or Work Phone							
		Patient Weight: Height: Allergies:					
Primary Insurance Name		□ IV access [for IVIg patients only]: _		□ Nur	se to place PIV prior to the	erapy	
Primary Insurance Group		Diagnosis	ICD-10) Diagr	Diagnosis		ICD-10
		Neuromuscular:	102		Immune Deficiency:		102 10
Insured Name	Insured Date of Birth	☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)) G61.81	□ CVID \	□ CVID w/ Predominant Immunoregulatory T-Cell Disorders		D83.1
mane wante	modica bate of birth	☐ Dermatopolymyositis	M33.90	☐ Combi	ned Immunodeficiency, Unspecified		D81.9
		☐ Guillain-Barre Syndrome (GBS)	G61.0	☐ Comm	☐ Common Variable Immunodeficiency, Unspecified		D83.9
Secondary Insurance Name Insurance ID Insurance Group		☐ Multifocal Motor Neuropathy	G61.82	☐ Heredi	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	avis with (Acute) Exacerbation G70.01		□ Nonfamilial Hypogammaglobulinemia		D80.1
Secondary modrance 1D Secondary modrance 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	25.82 ☐ Pemphigoid			L12.0
		Other:		☐ Pemphigus			L10.9
Address		☐ Autoimmune Encephalopathy	G04.81	□ SCID v	☐ SCID with 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	.89			D80.3
City, State, Zip				☐ Specifi	c Antibody Deficiency		D80.6
					stemic lupus erythematosus (SLE)		M32.9
Phone	Fax			DED 4			
1 10110		Please Draw:		PER Anaphylaxis Protocol:			
NIDI		□ CBC/diff □ CMP □ IgG w/subclasses 1-	.4 □ Ouant Iα		piPen 0.3 auto-injector dual pack – EpiPen 0.15 auto-injector dual pack		
NPI					intramuscularly in the event of ADR*		
Please fax the following	information:	□ □ Frequency:			x 1. Order is valid for 1 year]. **Use	generic if applicable	e**
☐ History and Physical ☐ Pertinent Lab Work		Notes:	If applicable, flush intravenous access device per KabaFusion protocol			n protocol:	
□ Front & Back copy(s) of patient's insurance card(s)			Access	S	NS	Heparin	
		j l	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 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.			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	
			Implanted Port		5-10mls before/after use; 20mls after blood draw	100 u/ml 5mls after last NS flush; 5mls after blood draw	
			Tunneled		5-10mls before/after use; 20mls	10 u/ml 3- mls after blood draw	

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