

Immunoglobulin Prescription Form Please fax completed order form to 833.543.0292

after blood draw

NO Heparin needed

Groshong PICC, Midline

5840 W. Las Positas Blyd LSuito 10 | Ploasanton CA 94588

OFFICE: 855.434.4844 FAX: 833.543.0292		<u>Prescription:</u>							
Demographic Information:		☐ Intravenous Immunoglobulin ☐ Subcutan				□ Subcutaneous In	neous Immunoglobulin		
		□ 0.4 gm/kg □1gm/kg □2gm/kg □ grams							
Patient Name	Date of Birth	Infuse: ☐ IV daily x day(s); repea	•		cycles	Infuse grams	OR mls	;	
Patient Name Date of Biltin		□ Other: using sites time(s) per w							
Home Address		Hydration order:		fused prior/post	IVIG.	for		(-)	
Home Address		□ Pre-medications: Acetaminophen 6							
City, State, Zip			25mg PO 30 mins pri						
City, State, Zip									
Home Phone	Mobile or Work Phone	<u>Clinical Information:</u>							
		Dakiash Walahk							
		Patient Weight: Height: Allergies:							
Primary Insurance Name	rimary Insurance Name □ IV access [for IVIg patients only]: □ Nurse to place PIV prior to therapy								
Primary Insurance ID Primary Insurance Group		Diagnosis		ICD-10	Diagnosis			ICD-10	
		Neuromuscular:			Immune	Deficiency:			
Insured Name	Insured Date of Birth	☐ Chronic Inflammatory Demyelinating Polyneum	ropathy (CIDP)	G61.81	□ CVID w	/ Predominant Immunoregulatory T-C	ell Disorders	D83.1	
		☐ Dermatopolymyositis		M33.90		ed Immunodeficiency, Unspecified		D81.9 D83.9	
Secondary Insurance Name Insurance ID Insurance Group		☐ Guillain-Barre Syndrome (GBS)		G61.0	□ Commo	☐ Common Variable Immunodeficiency, Unspecified			
		☐ Multifocal Motor Neuropathy		G61.82		Hereditary Hypogammaglobulinemia			
		☐ Myasthenia Gravis (MG)		G70.0		☐ Immunodeficiency with Increased IgM			
Secondary Insurance ID Secondary Insurance Group		☐ Myasthenia Gravis with (Acute) Exacerbation		G70.01	□ Nonfamilial Hypogammaglobulinemia			D80.1	
		□ Polymyositis		M33.20	☐ Other combined Immunodeficiencies			D81.89	
0.1		☐ Relapsing Remitting Multiple Sclerosis (RRMS)		G35	☐ Other Common Variable Immunodeficiencies			D83.9	
Ordering Physician's Name		☐ Stiff Person Syndrome		G25.82	□ Pemphigoid			L12.0	
		Other:			□ Pemphi	•		L10.9	
Address		☐ Autoimmune Encephalopathy		G04.81	□ SCID with Low or Normal B-Cell Numbers			D81.2 D81.1	
!		☐ Idiopathic Thrombocytopenic Purpura ☐ Inflammatory Neuropathies		D69.3	☐ SCID with Low T- and B- Cell Numbers ☐ Selective deficiency of IgG Subclasses			D81.1	
City, State, Zip		- Initianimatory Neuropathies		G61.89		Antibody Deficiency		D80.6	
orty, State, Lip					☐ Systemic lupus erythematosus (SLE)			M32.9	
					_ оузкени	e lapas erythematosas (SEE)			
Phone	Fax	Please Draw:	Р	PER Anaphylaxis Protocol:					
		□ CBC/diff □ CMP □ IgG w/subclasses 1-4			□ Adult – EpiPen 0.3 auto-injector dual pack □ Pediatric – EpiPen 0.15 auto-injector dual pack				
NPI									
		□ □ Fre	eauencv:			ntramuscularly in the event of ADR* 1. Order is valid for 1 year]. **Use	gonorio if applicab	0**	
Please fax the following	information:			Liv	iay repeat x	i. Order is valid for i year]. Ose	Jenene II applicabl		
□ History and Physical □ Pertinent Lab Work		Notes:	If a	If applicable, flush intravenous access device per KabaF			r KabaFusio	n protocol:	
□ Front & Back copy(s) of patient's insurance card(s)				Access		NS	Heparin		
				Peripheral		1-3ml before/after use		after last NS flush	
l authorize KabaFusion and its representatives to act as an agent and initiate and			Midline	e, central (non-por	t), PICC	NS 5-10 mls before/after use;	10 u/ml 3-5n	nls after last NS	
execute any insurance prior authorization process for this prescription, and any future						10mls after blood draw 5-10mls before/after use; 20mls	flush; 5mls after blood draw 100 u/ml 5mls after last NS		
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		after blood draw	flush; 5mls after blood draw		
				Tunneled		5-10mls before/after use; 20mls after blood draw		nls after last NS fter blood draw	
Physician Signature:						5-10mls before/after use; 10mls	NO Hoperin peeded		

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