KabaFusion
Patient-Focused Infusion Therapy

Immunoglobulin Prescription Form

Return Signed Rx via Fax to: 877.445.8821

Date:	To:	From:
Phone:	Fax:	Number of Pages:

Patient Information

Patient Name:	**DOB:**	**Height:**
Allergies:		**Weight:**

Medication Order

❒ **Intravenous Immunoglobulin**

❒ 0.4 gm/kg ❒ 1gm/kg ❒ 2gm/kg ☐ _____grams

Infuse: ❒ IV Daily for _____ day(s); repeat every _____ week(s) x _____ courses

❒ Other: _____

❒ **Subcutaneous Immunoglobulin**

Infuse_____grams OR _____ mLs _____ every _____ week for _____ months

Number of Infusion sites ___

Diagnosis	ICD-10	Diagnosis	ICD-10
❒Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	G61.81	❒CVID w/ Predominant Immunoregulatory T-cell Disorders	D83.1
❒Dermatopolymyositis	M33.90	❒Combined Immunodeficiency	D81.9
❒Guillain-Barre Syndrome (GBS)	G61.0	❒Common Variable Immunodeficiency, Unspecified	D83.9
❒Multifocal Motor Neuropathy	G61.82	❒Hereditary Hypogammaglobulinemia	D80.0
❒Myasthenia Gravis (Refractory to current treatment)	G70.0	❒Specific Antibody Deficiency	D80.6
❒Myasthenia Gravis with (Acute) Exacerbation	G70.01	❒Nonfamilial Hypogammaglobulinemia	D80.1
❒Polymyositis	M33.20	❒Other combined Immunodeficiencies	D81.89
❒Relapsing-Remitting Multiple Sclerosis (RRMS)	G35	❒SCID with Low or Normal B-cell Numbers	D81.2
❒Stiff Person Syndrome	G25.82	❒SCID with Low T-and B-cell Numbers	D81.1
❒Autoimmune Encephalopathy	G04.81	❒Selective deficiency of IgG Subclasses	D80.3
❒Inflammatory Neuropathies	G61.89	❒Systemic lupus erythematosus	M32.9
❒Pemphigoid	L12.0	❒ Idiopathic Thrombocytopenic	D69.3
❒Pemphigus	L10.9	❒ Other:	

IV Access Device: ☐ Peripheral ☐ Central

Lab: ❒ CBC/diff ❒CMP ❒ IgG w subclasses 1-4 ❒ Quant. Ig
❒ Other: _____ Frequency: _____

Pre-medications:

❒ Diphenhydramine: _____ ❒ PO ❒ IV
❒ Acetaminophen: _____ ❒ PO ❒ IV
❒ Other _____

❒ **Hydration:** 500 mL of Normal Saline with IVIg infusion

❒ **Anaphylaxis Protocol: Epinephrine Auto-Injector dual pack**
Adult: 0.3 mg Children: 0.15 mg
Administer epinephrine IM in the event of anaphylaxis.
May repeat x 1 as needed, Call 911. **Refill x 1yr**

If applicable, flush IV access device per KabaFusion protocol:

Access	NS	Heparin
Peripheral	1-3 mL before/after use	10 U/mL 1-2 mL after last NS flush
Midline, Central (non-port), PICC	5-10 ml before/after use 5-20 ml after blood draw	10 U/mL 3-5 mL after last NS flush 5 mL after the blood draw
Implanted Port	5-10 mL before/after use. 20mL after blood draw	100 U/mL 5 mL after last NS flush 5 mL after the blood draw
Tunneled	5-10 mL before/after use 20mL after blood draw	10 U/mL 3-5 mL after last NS flush 5 mL after the blood draw
Groshong PICC, Midline	5-10 mL before/after use 10 mL after blood draw	None

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.

Prescriber Signature: _____ Date: _____

Print Prescriber Name: _____ NPI#: _____

DOCUMENTATION – PLEASE FAX TO KABAFUSION

☐ **Rx Order** – include dose, route of administration, frequency, duration, & pre-medications OR use the Rx order form above
☐ **Patient Demographics** – include **insurance** information. We will obtain authorization unless the insurance dictates otherwise.
☐ **H & P OR progress note(s)** describing diagnosis, clinical status, and clinical symptoms.
☐ Most recent lab results for: **BUN/Creatinine, CMP Panel and CBC with Differential**