



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

<input type="checkbox"/> Intravenous Immunoglobulin <input type="checkbox"/> 0.4 gm/kg <input type="checkbox"/> 1gm/kg <input type="checkbox"/> 2gm/kg <input type="checkbox"/> ____grams Infuse: <input type="checkbox"/> IV Daily for ____ day(s); repeat every ____ week(s) x ____ courses <input type="checkbox"/> Other: _____	<input type="checkbox"/> Subcutaneous Immunoglobulin Infuse ____grams OR ____ mLs ____ every ____ week for ____ months Number of Infusion sites ____
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Diagnosis	ICD-10	Diagnosis	ICD-10
<input type="checkbox"/> Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	G61.81	<input type="checkbox"/> CVID w/ Predominant Immunoregulatory T-cell Disorders	D83.1
<input type="checkbox"/> Dermatopolymyositis	M33.90	<input type="checkbox"/> Combined Immunodeficiency	D81.9
<input type="checkbox"/> Guillain-Barre Syndrome (GBS)	G61.0	<input type="checkbox"/> Common Variable Immunodeficiency, Unspecified	D83.9
<input type="checkbox"/> Multifocal Motor Neuropathy	G61.82	<input type="checkbox"/> Hereditary Hypogammaglobulinemia	D80.0
<input type="checkbox"/> Myasthenia Gravis (Refractory to current treatment)	G70.0	<input type="checkbox"/> Specific Antibody Deficiency	D80.6
<input type="checkbox"/> Myasthenia Gravis with (Acute) Exacerbation	G70.01	<input type="checkbox"/> Nonfamilial Hypogammaglobulinemia	D80.1
<input type="checkbox"/> Polymyositis	M33.20	<input type="checkbox"/> Other combined Immunodeficiencies	D81.89
<input type="checkbox"/> Relapsing-Remitting Multiple Sclerosis (RRMS)	G35	<input type="checkbox"/> SCID with Low or Normal B-cell Numbers	D81.2
<input type="checkbox"/> Stiff Person Syndrome	G25.82	<input type="checkbox"/> SCID with Low T-and B-cell Numbers	D81.1
<input type="checkbox"/> Autoimmune Encephalopathy	G04.81	<input type="checkbox"/> Selective deficiency of IgG Subclasses	D80.3
<input type="checkbox"/> Inflammatory Neuropathies	G61.89	<input type="checkbox"/> Systemic lupus erythematosus	M32.9
<input type="checkbox"/> Pemphigoid	L12.0	<input type="checkbox"/> Idiopathic Thrombocytopenic	D69.3
<input type="checkbox"/> Pemphigus	L10.9	<input type="checkbox"/> Other:	

IV Access Device: <input type="checkbox"/> Peripheral <input type="checkbox"/> Central	Lab: <input type="checkbox"/> CBC/diff <input type="checkbox"/> CMP <input type="checkbox"/> IgG w subclasses 1-4 <input type="checkbox"/> Quant. Ig <input type="checkbox"/> Other: _____ Frequency: _____
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Pre-medications: <input type="checkbox"/> Diphenhydramine: _____ <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Acetaminophen: _____ <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Other _____ <input type="checkbox"/> Hydration: 500 mL of Normal Saline with IVIg infusion <input type="checkbox"/> 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: <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:25%;">Access</th> <th style="width:25%;">NS</th> <th style="width:50%;">Heparin</th> </tr> </thead> <tbody> <tr> <td>Peripheral</td> <td>1-3 mL before/after use</td> <td>10 U/mL 1-2 mL after last NS flush</td> </tr> <tr> <td>Midline, Central (non-port), PICC</td> <td>5-10 ml before/after use 5-20 ml after blood draw</td> <td>10 U/mL 3-5 mL after last NS flush 5 mL after the blood draw</td> </tr> <tr> <td>Implanted Port</td> <td>5-10 mL before/after use. 20mL after blood draw</td> <td>100 U/mL 5 mL after last NS flush 5 mL after the blood draw</td> </tr> <tr> <td>Tunneled</td> <td>5-10 mL before/after use 20mL after blood draw</td> <td>10 U/mL 3-5 mL after last NS flush 5 mL after the blood draw</td> </tr> <tr> <td>Groshong PICC, Midline</td> <td>5-10 mL before/after use 10 mL after blood draw</td> <td>None</td> </tr> </tbody> </table>	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
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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**

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