

Immunoglobulin Prescription Form Please fax completed order form to 888.837.2716

after blood draw

NO Heparin needed

Groshong PICC, Midline

3000 Kellway Drive | Suite 110 | Carrollton, TX 75006

OFFICE: 800.333.0660 FAX: 888.837.2716							
Demographic Information:	□ Intravenous Immunoglob	□ Intravenous Immunoglobulin □ Subcutaneous Immunoglobulin					
	□ 0.4 gm/kg □1gm/kg □2gm/	/kg □ grams					
Patient Name Date	of Birth Infuse: IV daily x day(s); repe	at every week(s) x	cycles	Infuse grams	OR mls	i	
	□ Other:			using sites	time	(s) per week	
Home Address	Hydration order:	mls NS iv to be infused prior	/post IVIG.	for	months.		
	 Pre-medications: Acetaminophen 6 			er Pre-medications:			
City, State, Zip	— Diphenhydramine	e 25mg PO 30 mins prior to infus	sion				
	Clinical Information:						
Home Phone Mobile or Work Phone	<u>Clinical Information:</u>						
	Patient Weight:	Patient Weight: Height: Allergies:					
Primary Insurance Name							
	 IV access [for IVIg patient 	s only]:		se to place PIV prior to the	rapy		
Primary Insurance ID Primary Insurance Gro	Diagnosis	ICD-1	0 Diagr	nosis		ICD-10	
	Neuromuscular:			Deficiency:			
Insured Name Insured Date of Birth	☐ Chronic Inflammatory Demyelinating Polyneu	uropathy (CIDP) G61.8	I □ CVID v	v/ Predominant Immunoregulatory T-0	ell Disorders	D83.1	
	□ Dermatopolymyositis	M33.90		ned Immunodeficiency, Unspecified		D81.9	
Cocondon Incurrence Name Incurrence ID Incu	☐ Guillain-Barre Syndrome (GBS)	G61.0		on Variable Immunodeficiency, Unspec	ified	D83.9	
Secondary Insurance Name Insurance ID Insu	rance Group ☐ Multifocal Motor Neuropathy	G61.82		tary Hypogammaglobulinemia		D80.0 D80.5	
	☐ Myasthenia Gravis (MG) ☐ Myasthenia Gravis with (Acute) Exacerbation	G70.0		nodeficiency with Increased IgM nilial Hypogammaglobulinemia		D80.5	
Secondary Insurance ID Secondary Insuran	nce Group □ Polymyositis	G70.0° M33.20		combined Immunodeficiencies		D81.89	
	☐ Relapsing Remitting Multiple Sclerosis (RRMS		_	Common Variable Immunodeficiencies		D83.9	
Ordering Physician's Name	☐ Stiff Person Syndrome	G25.82				L12.0	
	Other:		□ Pemph	•		L10.9	
Address	☐ Autoimmune Encephalopathy	G04.8	I □ SCID v	with Low or Normal B-Cell Numbers		D81.2	
Address	☐ Idiopathic Thrombocytopenic Purpura	D69.3	□ SCID v	vith Low T- and B- Cell Numbers		D81.1	
	☐ Inflammatory Neuropathies	G61.89	9 □ Selecti	ve deficiency of IgG Subclasses		D80.3	
City, State, Zip				c Antibody Deficiency		D80.6	
			☐ System	nic lupus erythematosus (SLE)		M32.9	
Phone Fax	Places Provide		DED Δna	phylaxis Protocol:			
	Please Draw:			piPen 0.3 auto-injector dual pack			
NPI	□ CBC/diff □ CMP □ IgG w/su	ıbclasses 1-4 🛛 Quant. Ig		- EpiPen 0.15 auto-injector dual pack			
		requency:	* Administer	intramuscularly in the event of ADR* x 1. Order is valid for 1 year]. **Use	generic if applicab	o**	
Please fax the following information:		1	[iviay repeat	x i. Order is valid for i year].	денене п аррпсаві		
□ History and Physical □ Pertinent Lab Work	Notes:	If applicab	e, flush inti	ravenous access device pe	er KabaFusio	n protocol:	
☐ Front & Back copy(s) of patient's insurance card(s		Acce	Access NS		He	parin	
E From a back copy(s) of patients insurance card(s		Periphe		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		Midline, central (n	on-port), PICC	NS 5-10 mls before/after use; 10mls after blood draw		nls after last NS fter blood draw	
execute any insurance prior authorization process for this prescriptio fills of the same prescription for the patient listed above. I understan		Implante	Implanted Port 5-10mls before/after use; 20mls		100 u/ml 5m	ls after last NS	
revoke this designation at any time by providing written notice to Kal		·	5 10mls before/after use: 20mls			flush; 5mls after blood draw 10 u/ml 3- mls after last NS	
Physician Signature:					flush. 5mls a	flush. 5mls after blood draw	

Prescription ·

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