

Physician Signature:_

Immunoglobulin Prescription Form Please fax completed order form to 877.239.8117

5-10mls before/after use; 10mls

after blood draw

NO Heparin needed

Groshong PICC, Midline

129 N. White Horse Pike | Suie 1 | Hammonton, NJ 08037 OFFICE: 609.567.2241 | FAX: 877.239.8117

OFFICE: 609.567.2241 F	AX: 877.239.8117	<u>rrescription.</u>						
Demographic Information:		☐ Intravenous Immunoglobulin ☐ Subcutaneous Immunoglobulin						ulin
Demograpme miorina	tion.	□ 0.4 gm/kg □1gm/k	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						i
Tationt Numb	Date of Birtin	□ Other:				using sites		
Home Address		Hydration order:			oost IVIG	for		
nome Address		-				er Pre-medications:		
			hydramine 25mg PO 30	•		. Tre-medications.		
City, State, Zip		·	,	•				
		Clinical Information:						
Home Phone	Mobile or Work Phone							
		Patient Weight:		Allergies:				
Primary Insurance Name								
		□ IV access [for IVI	g patients only]:		□ Nurs	se to place PIV prior to the	erapy	
Primary Insurance Group Primary Insurance Group		Diagnosis		ICD-10	Diagnosis			ICD-10
		Neuromuscular:	TOD-10		Immune Deficiency:			
		☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)		G61.81		□ CVID w/ Predominant Immunoregulatory T-Cell Disorders		D83.1
Insured Name	Insured Date of Birth	□ Dermatopolymyositis	9 ·,··, ()	M33.90		ned Immunodeficiency, Unspecified		D81.9
		☐ Guillain-Barre Syndrome (GBS)		G61.0		on Variable Immunodeficiency, Unspec	ified	D83.9
Secondary Insurance Name	Insurance ID Insurance Group	☐ Multifocal Motor Neuropathy		G61.82		☐ Hereditary Hypogammaglobulinemia		
•	·	☐ Myasthenia Gravis (MG)		G70.0		odeficiency with Increased IgM		D80.5
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
		☐ Relapsing Remitting Multiple Scle	erosis (RRMS)	G35	□ Other (Common Variable Immunodeficiencies		D83.9
Ordering Physician's Name		□ Stiff Person Syndrome		G25.82	□ Pemphigoid			L12.0
		Other:		020.02	□ Pemphigus			L10.9
		☐ Autoimmune Encephalopathy		G04.81	□ 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	☐ Selective deficiency of IgG Subclasses			D80.3
City, State, Zip	_	, ,				Antibody Deficiency		D80.6
3 . , 1				□ Systemic		nic lupus erythematosus (SLE)		M32.9
				l				
Phone Fax		Please Draw:		PER Ana	phylaxis Protocol:			
		Flease Draw.				iPen 0.3 auto-injector dual pack		
NPI		□ CBC/diff □ CMP □ IgG w/subclasses 1-4 □ □ Frequency: □		4 □ Quant. Ig □ Pediatric – EpiPen 0.15 auto-injector dual pack * Administer intramuscularly in the event of ADR*		·		
Please fax the following	information:		Trequency.		[May repeat :	x 1. Order is valid for 1 year]. **Use	generic if applicabl	e**
Libetann and Dhariad — Dankin ant Lah Want		Notes:		If applicable, flush intravenous access device per KabaFusion protocol:				
□ History and Physical □ Pertinent Lab Work								
☐ Front & Back copy(s) of patient's insurance card(s)				Access		NS	Heparin 10u/ml 1-2mls after last NS flush	
		1]}	Peripher	al	1-3ml before/after use NS 5-10 mls before/after use:		
authorize KabaFusion and its representatives to act as an agent and initiate and				Midline, central (non-port),		10mls after blood draw	10 u/ml 3-5mls after last NS flush; 5mls after blood draw	
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				Implanted Port		5-10mls before/after use; 20mls	100 u/ml 5m	ils after last NS
revoke this designation at any time by providing written notice to KabaFusion.				<u>'</u>		after blood draw 5-10mls before/after use; 20mls		fter blood draw nls after last NS
9 , 1 1 1				Tunnele	t	after blood draw		fter blood draw

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