

Immunoglobulin Prescription Form Please fax completed order form to 629.204.6596

2970 Sidco Drive I Nashville, TN 37204

OFFICE: 877.397.8341 F	AX: 629.204.6596	<u>Prescription:</u>					
'		☐ Intravenous Immunoglobulin ☐ Subcutaneous Immunoglobulin					ulin
<u>Demographic Informa</u>	ation:	□ 0.4 gm/kg □1gm/kg □2gm/kg □	grams				
Patient Name Date of Birth		Infuse: IV daily x day(s); repeat every week(s) x cycles Infuse grams OR Other: using sites					
Home Address		Hydration order:mls NS iv to be infused prior/post IVIG. formonths. □ Pre-medications: Acetaminophen 650mg PO 30 mins prior to infusion □ Other Pre-medications: Diphenhydramine 25mg PO 30 mins prior to infusion					
City, State, Zip		Dipriently dramine 25 mg FO 50 m	Tillis prior to illiusion				
Home Phone Mobile or Work Phone Clinical Information: Patient Weight: Height: Allergies:							
Primary Insurance Name		□ IV access [for IVIg patients only]:		□ Nurs	se to place PIV prior to the	erapy	
Primary Insurance ID Primary Insurance Group		Diagnosis	ICD-10	Diagnosis			ICD-10
		Neuromuscular:			Deficiency:		D83.1
Insured Name Insured Date of Birth		☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	G61.81	_	□ CVID w/ Predominant Immunoregulatory T-Cell Disorders		
		□ Dermatopolymyositis	M33.90		ned Immunodeficiency, Unspecified		D81.9 D83.9
Secondary Insurance Name	Insurance ID Insurance Group	☐ Guillain-Barre Syndrome (GBS)	G61.0	_	☐ Common Variable Immunodeficiency, Unspecified		
Secondary mourance warne	Insurance ID Insurance Group	☐ Multifocal Motor Neuropathy	G61.82		☐ Hereditary Hypogammaglobulinemia		D80.0 D80.5
		☐ Myasthenia Gravis (MG)	G70.0		odeficiency with Increased IgM		D80.5 D80.1
Secondary Insurance ID	Secondary Insurance Group	☐ Myasthenia Gravis with (Acute) Exacerbation ☐ Polymyositis	G70.01	☐ Nonfamilial Hypogammaglobulinemia ☐ Other combined Immunodeficiencies			D81.89
		☐ Relapsing Remitting Multiple Sclerosis (RRMS)	M33.20		☐ Other Common Variable Immunodeficiencies		D83.9
Ordering Physician's Name		☐ Stiff Person Syndrome		G35 □ Other Common Variable Immunodeficiencies G25.82 □ Pemphigoid			L12.0
		Other:	G25.62	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				D80.3
City, State, Zip				☐ Specific	c Antibody Deficiency		D80.6
				☐ System	ic lupus erythematosus (SLE)		M32.9
Phone	Fax	Please Draw: □ CBC/diff □ CMP □ IgG w/subclasses 1-4 □ □ Frequency:	• •	Quant. Ig PER Anaphylaxis Protocol: Adult – EpiPen 0.3 auto-injector dual pack Pediatric – EpiPen 0.15 auto-injector dual pack Administer intramuscularly in the event of ADR* [May repeat x 1. Order is valid for 1 year]. **Use generic if applicable**			
Please fax the following	information:			[way repeat	k i. Order is valid for i year].	денене н аррнсав	
□ History and Physical □ Pertinent Lab Work		Notes:	If applicable, flush intravenous access device per KabaFusi			er KabaFusio	n protocol:
☐ Front & Back copy(s) of patient's insurance card(s)			Access		NS	Heparin	
		<u> </u>	Peripheral		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 initiate and execute any insurance prior authorization process for this prescription, and any future					NS 5-10 mls before/after use; 10mls after blood draw	10 u/ml 3-5mls after last NS flush; 5mls after blood draw	
fills of the same prescription for the patient listed above. I understand that I can					5-10mls before/after use; 20mls after blood draw	nls 100 u/ml 5mls after last NS flush; 5mls after blood draw	
revoke this designation at any time by providing written notice to KabaFusion.			Tunneled		5-10mls before/after use; 20mls after blood draw	10 u/ml 3- mls after last NS flush. 5mls after blood draw	
Physician Signature:			Crashana DICC Midlins		5-10mls before/after use; 10mls	re/after use; 10mls	

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Groshong PICC, Midline

NO Heparin needed

after blood draw