

Immunoglobulin Prescription Form Please fax completed order form to 734.425.0470

28550 Cabot Drive | Suite 200 | Novi. MI 48377

OFFICE: 734.425.2550 F	AX: 734.425.0470	<u>Prescription:</u>					
·		☐ Intravenous Immunoglobulin ☐ Subcutaneous Immunoglobu					ulin
<u>Demographic Information:</u>		□ 0.4 gm/kg □1gm/kg □2gm/kg □ grams					
Patient Name	Date of Birth	Infuse: ☐ IV daily x day(s); repeat every		cycles	Infuse grams	OR mls	3
Patient Name	Date of bil th	□ Other:		,	using sites		
Home Address		Hydration order:mls NS iv to be infused prior/post IVIG. formonths.					
		□ Pre-medications: Acetaminophen 650mg PO 30			er Pre-medications:		
City, State, Zip		Diphenhydramine 25mg PO 30) mins prior to infusion	1			
		<u>Clinical Information:</u>					
Home Phone Mobile or Work Phone		Patient Weight: Height: Allergies:					
Primary Insurance Name							
		IV access [for IVIg patients only]:		□ Nurs	se to place PIV prior to the	erapy	
Primary Insurance Group		Diagnosis	ICD-10	Diagr	Diagnosis		ICD-10
		Neuromuscular:			nmune Deficiency:		
Insured Name Insured Date of Birth		☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)) G61.81	□ CVID v	□ CVID w/ Predominant Immunoregulatory T-Cell Disorders		D83.1
		□ Dermatopolymyositis	M33.90	☐ Combi	ned Immunodeficiency, Unspecified		D81.9
Secondary Insurance Name Insurance ID Insurance Group		☐ Guillain-Barre Syndrome (GBS)	G61.0	☐ Comm	☐ Common Variable Immunodeficiency, Unspecified		D83.9
		☐ Multifocal Motor Neuropathy	G61.82		☐ Hereditary Hypogammaglobulinemia		D80.0
		☐ Myasthenia Gravis (MG)	G70.0		mmunodeficiency 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		combined Immunodeficiencies		D81.89
Ondering Discriptor/s Name		☐ Relapsing Remitting Multiple Sclerosis (RRMS) G35		Other Common Variable Immunodeficiencies		D83.9	
Ordering Physician's Name		☐ Stiff Person Syndrome	G25.82	□ Pemphigoid			L12.0
		Other:		□ Pemph			L10.9 D81.2
Address		☐ Autoimmune Encephalopathy	G04.81	□ SCID with Low or Normal B-Cell Numbers			D81.2
		☐ Idiopathic Thrombocytopenic Purpura ☐ Inflammatory Neuropathies	D69.3	☐ SCID with Low T- and B- Cell Numbers ☐ Selective deficiency of IgG Subclasses		D80.3	
City, State, Zip	-	- Initialification y Neuropatriles	G61.89		c Antibody Deficiency		D80.6
City, State, Zip					nic lupus erythematosus (SLE)		M32.9
				_ ojsto:	no rapus orytmomatosus (ezz)		
Phone	Fax	Please Draw: PER Anaphylaxis Protocol:					
				□ Adult – Ep	piPen 0.3 auto-injector dual pack		
NPI		□ CBC/diff □ CMP □ IgG w/subclasses 1-	-4 🗆 Quant. Ig		- EpiPen 0.15 auto-injector dual pack		
Please fax the following	information:	□ □ Frequency:		* Administer [May repeat	intramuscularly in the event of ADR* x 1. Order is valid for 1 year]. **Use	generic if applicab	le**
r lease tax the following	information.	Notes:	If applicable	fluch int	ravanaus agass daviga no	r VahaEusia	n protocol:
☐ History and Physical ☐ Pertinent Lab Work		Notes.	If applicable, flush intravenous access device per KabaFusio			n protocoi:	
□ Front & Back copy(s) of patient's insurance card(s)			Access		NS	Heparin	
			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					NS 5-10 mls before/after use; 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					5-10mls before/after use; 20mls 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:			Crochong BICC Midling		5-10mls before/after use; 10mls	NO Hoperin peeded	

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Groshong PICC, Midline

NO Heparin needed

after blood draw