KabaFusion
Patient-Focused Infusion Therapy

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Phone: 888.211.7439 | eFax: 854.999.4977

Immunoglobulin Prescription Form

Please fax completed order form to 854.999.4977

Demographic Information:

Patient Name | Date of Birth

Home Address

City, State, Zip

Home Phone | Mobile or Work Phone

Primary Insurance Name

Primary Insurance ID | Primary Insurance Group

Insured Name | Insured Date of Birth

Secondary Insurance Name | Insurance ID | Insurance Group

Secondary Insurance ID | Secondary Insurance Group

Ordering Physician's Name

Address

City, State, Zip

Phone | Fax

NPI

Please fax the following information:

☐ History and Physical ☐ Pertinent Lab Work
☐ Front & Back copy(s) of patient's insurance card(s)

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.

Physician Signature:_____

Date: _____

Prescription:

☐ **Intravenous Immunoglobulin** ☐ **Subcutaneous Immunoglobulin**

☐0.4 gm/kg ☐1gm/kg ☐2gm/kg ☐_____ grams

Infuse: ☐IV daily x _____ day(s); repeat every _____ week(s) x _____ cycles

☐Other: _____

Hydration order: _____mls NS iv to be infused prior/post IVIG.

☐ Pre-medications: Acetaminophen 650mg PO 30 mins prior to infusion
Diphenhydramine 25mg PO 30 mins prior to infusion

☐ Other Pre-medications: _____

Infuse _____ grams OR _____ mls
using _____ sites _____ time(s) per week
for_____months.

Clinical Information:

Patient Weight: _____ Height: _____ Allergies: _____

☐ IV access [for IVIg patients only]: _____ ☐ Nurse to place PIV prior to therapy

Diagnosis	ICD-10	Diagnosis	ICD-10
Neuromuscular:		**Immune Deficiency:**	
☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	G61.81	☐ CVID w/ Predominant Immunoregulatory T-Cell Disorders	D83.1
☐ Dermatopolymyositis	M33.90	☐ Combined Immunodeficiency, Unspecified	D81.9
☐ Guillain-Barre Syndrome (GBS)	G61.0	☐ Common Variable Immunodeficiency, Unspecified	D83.9
☐ Multifocal Motor Neuropathy	G61.82	☐ Hereditary Hypogammaglobulinemia	D80.0
☐ Myasthenia Gravis (MG)	G70.0	☐ Immunodeficiency with Increased IgM	D80.5
☐ Myasthenia Gravis with (Acute) Exacerbation	G70.01	☐ Nonfamilial Hypogammaglobulinemia	D80.1
☐ Polymyositis	M33.20	☐ Other combined Immunodeficiencies	D81.89
☐ Relapsing Remitting Multiple Sclerosis (RRMS)	G35	☐ Other Common Variable Immunodeficiencies	D83.9
☐ Stiff Person Syndrome	G25.82	☐ Pemphigoid	L12.0
Other:		☐ Pemphigus	L10.9
☐ Autoimmune Encephalopathy	G04.81	☐ SCID with Low or Normal B-Cell Numbers	D81.2
☐ 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
		☐ Specific Antibody Deficiency	D80.6
		☐ Systemic lupus erythematosus (SLE)	M32.9

Please Draw:

☐ CBC/diff ☐ CMP ☐ IgG w/subclasses 1-4 ☐ Quant. Ig
☐ _____ ☐ _____ Frequency: _____

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**

Notes:

If applicable, flush intravenous access device per KabaFusion protocol:

Access	NS	Heparin
Peripheral	1-3ml before/after use	10u/ml 1-2mls after last NS flush
Midline, central (non-port), PICC	NS 5-10 mls before/after use; 10mls after blood draw	10 u/ml 3-5mls after last NS flush; 5mls after blood draw
Implanted Port	5-10mls before/after use; 20mls after blood draw	100 u/ml 5mls after last NS flush; 5mls after blood draw
Tunneled	5-10mls before/after use; 20mls after blood draw	10 u/ml 3- mls after last NS flush. 5mls after blood draw
Groshong PICC, Midline	5-10mls before/after use; 10mls after blood draw	NO Heparin needed

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