

Demographic Information:

Patient Last Name _____

Patient First 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)

Physician Signature: _____

Date: _____

Prescription:

Intravenous Immunoglobulin

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

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

Other: _____

Subcutaneous Immunoglobulin

Infuse _____ grams OR _____ mls using _____

sites _____ time(s) per week for _____ months.

Hydration order: _____ mls NS iv to be infused prior/concurrently with IVIG.

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

Other: _____

Diphenhydramine 25mg PO 30 mins prior to infusion

Other Pre-medications: _____

Clinical Information:

Patient Weight: _____ Height: _____ Allergies: _____

IV access [for IVIg patients only]: _____

Nurse to place PIV prior to therapy

Diagnosis	ICD-9	ICD-10
Neuromuscular:		
<input type="checkbox"/> Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	357.81	G61.81
<input type="checkbox"/> Guillain-Barre Syndrome (GBS)	357	G61.0
<input type="checkbox"/> Multiple Sclerosis (MS)	340.0	G35
<input type="checkbox"/> Myasthenia Gravis with (Acute) Exacerbation	358.01	G70.01
<input type="checkbox"/> Myasthenia Gravis (MG)	358.00	G70.0
<input type="checkbox"/> Polymyositis, Organ Involvement Unspecified	710.4	M33.20
<input type="checkbox"/> Dermatopolymyositis & Organ Involvement Unspecified	710.3	M33.90
<input type="checkbox"/> Stiff Person Syndrome	333.91	G25.82
Other:		
<input type="checkbox"/> BMT	V42.81	Z94.81
<input type="checkbox"/> Lymphoid Leukemia	204.10	C91.10
<input type="checkbox"/> Multiple Myeloma	203.00	C90.0
<input type="checkbox"/> Plasma Cell Leukemia	203.10	C90.1
<input type="checkbox"/> Thrombocytopenia	287.50	D69.6
<input type="checkbox"/> Prophylactic Immunotherapy	V07.20	Z41.8
<input type="checkbox"/> Other Peripheral Neuropathy	356.80	G62.9
<input type="checkbox"/> Other:		

Diagnosis	ICD-9	ICD-10
Immune Deficiency:		
<input type="checkbox"/> CVID w/ Predominant Immunoregulatory T-Cell Disorders	279.10	D83.1
<input type="checkbox"/> Combined Immunodeficiency, Unspecified	279.2	D81.9
<input type="checkbox"/> SCID with Low T- and B- Cell Numbers	279.2	D81.1
<input type="checkbox"/> SCID with Low or Normal B-Cell Numbers	279.2	D81.2
<input type="checkbox"/> Other combined Immunodeficiencies	279.2	D81.89
<input type="checkbox"/> Nonfamilial Hypogammaglobulinemia	279.0	D80.1
<input type="checkbox"/> Selective deficiency of IgA	279.01	D80.2
<input type="checkbox"/> Selective deficiency of IgM	279.02	D80.4
<input type="checkbox"/> Selective deficiency of IgG Subclasses	279.03	D80.3
<input type="checkbox"/> Hereditary Hypogammaglobulinemia	279.04	D80.0
<input type="checkbox"/> Immunodeficiency with Increased IgM	279.05	D80.5
<input type="checkbox"/> Other Common Variable Immunodeficiencies	279.06	D83.8
<input type="checkbox"/> Common Variable Immunodeficiency, Unspecified	279.06	D83.9
<input type="checkbox"/> Epidermolysis Bullosa	757.39	Q81.9
<input type="checkbox"/> Kawasaki's syndrome	446.10	M30.3
<input type="checkbox"/> Pemphigoid	694.5	L12.0
<input type="checkbox"/> Pemphigus	694.40	L10.9
<input type="checkbox"/> Systemic lupus erythematosus (SLE)	710.00	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 100 u/ml
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