



17777 Center Court Drive, Suite 175, Cerritos, CA 90703  
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# Immunoglobulin Prescription Form

*Please fax completed order form to 877.445.8821*

**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)

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 Infuse \_\_\_\_\_ grams OR \_\_\_\_\_ mls

Other: \_\_\_\_\_ using \_\_\_\_\_ sites \_\_\_\_\_ time(s) per week

Hydration order: \_\_\_\_\_ mls NS iv to be infused prior/post IVIG. for \_\_\_\_\_ months.

Pre-medications: Acetaminophen 650mg PO 30 mins prior to infusion  Other Pre-medications: \_\_\_\_\_  
Diphenhydramine 25mg PO 30 mins prior to infusion

**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
<b>Neuromuscular:</b>		<b>Immune Deficiency:</b>	
<input type="checkbox"/> Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	G61.81	<input type="checkbox"/> CVID w/ Predominant Immunoregulatory T-Cell Disorders	D83.1
<input type="checkbox"/> Dermatopolymyositis	M33.90	<input type="checkbox"/> Combined Immunodeficiency, Unspecified	D81.9
<input type="checkbox"/> Guillain-Barre Syndrome (GBS)	G61.0	<input type="checkbox"/> Common Variable Immunodeficiency, Unspecified	D83.9
<input type="checkbox"/> Multifocal Motor Neuropathy	G61.82	<input type="checkbox"/> Hereditary Hypogammaglobulinemia	D80.0
<input type="checkbox"/> Myasthenia Gravis (MG)	G70.0	<input type="checkbox"/> Immunodeficiency with Increased IgM	D80.5
<input type="checkbox"/> Myasthenia Gravis with (Acute) Exacerbation	G70.01	<input type="checkbox"/> Nonfamilial Hypogammaglobulinemia	D80.1
<input type="checkbox"/> Polymyositis	M33.20	<input type="checkbox"/> Other combined Immunodeficiencies	D81.89
<input type="checkbox"/> Relapsing Remitting Multiple Sclerosis (RRMS)	G35	<input type="checkbox"/> Other Common Variable Immunodeficiencies	D83.9
<input type="checkbox"/> Stiff Person Syndrome	G25.82	<input type="checkbox"/> Pemphigoid	L12.0
<b>Other:</b>		<input type="checkbox"/> Pemphigus	L10.9
<input type="checkbox"/> Autoimmune Encephalopathy	G04.81	<input type="checkbox"/> SCID with Low or Normal B-Cell Numbers	D81.2
<input type="checkbox"/> Idiopathic Thrombocytopenic Purpura	D69.3	<input type="checkbox"/> SCID with Low T- and B- Cell Numbers	D81.1
<input type="checkbox"/> Inflammatory Neuropathies	G61.89	<input type="checkbox"/> Selective deficiency of IgG Subclasses	D80.3
		<input type="checkbox"/> Specific Antibody Deficiency	D80.6
		<input type="checkbox"/> 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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