

**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**

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

**Subcutaneous Immunoglobulin**

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
<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