KabaFusion
Patient-Focused Infusion Therapy

159 Memorial Dr. | Suite E | Shrewsbury, MA 02545
OFFICE: 888.727.2323 | FAX: 888.966.0416

Immunoglobulin Prescription Form

Please fax completed order form to 888.966.0416

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
Diphenhydramine 25mg PO 30 mins prior to infusion

☐ **Subcutaneous Immunoglobulin**

Infuse _______ grams OR ______ mls

using _________ sites __________ time(s) per week

for_________months.

☐ Other Pre-medications: _______________

Clinical Information:

Patient Weight: ____________ Height: ____________ Allergies: ____________

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

Diagnosis (Neuromuscular):	ICD-10	Diagnosis (Immune Deficiency):	ICD-10
☐ Anemia with parvovirus B19	B34.3		
☐ Antiphospholipid syndrome	D68.61		
☐ Autoimmune Encephalopathy	G04.81		
☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	G61.81		
☐ Chronic Severe Myasthenia Gravis with Exacerbation & Disability	G70.01		
☐ Dermatomyositis	M33.90	☐ CVID w/ Predominant Immunoregulatory T-Cell Disorders	D83.1
☐ Guillain-Barre Syndrome (GBS)	G61.0	☐ Combined Immunodeficiency, Unspecified	D81.9
☐ Hereditary sensory neuropathy	G60.0	☐ Common Variable Immunodeficiency, Unspecified	D83.9
☐ Idiopathic Progressive Polyneuropathy	G60.3	☐ Hereditary Hypogammaglobulinemia	D80.0
☐ Idiopathic Thrombocytopenic Purpura	D69.3	☐ Immunodeficiency with Increased IgM	D80.5
☐ Multifocal Motor Neuropathy	G61.82	☐ Nonfamilial Hypogammaglobulinemia	D80.1
☐ Multiple myeloma and immunoproliferative neoplasms	C90.0	☐ Other combined Immunodeficiencies	D81.89
☐ Myasthenic Crisis	G70.01	☐ Other Common Variable Immunodeficiencies	D83.9
☐ PANDAS / PANS	D89.9	☐ Pemphigoid	L12.0
☐ Peroneal muscular atrophy	G04.81	☐ Pemphigus	L10.9
☐ Polymyositis	M33.20	☐ SCID with Low or Normal B-Cell Numbers	D81.2
☐ Relapsing Remitting Multiple Sclerosis (RRMS)	G35	☐ SCID with Low T- and B- Cell Numbers	D81.1
☐ Severe Refractory Myasthenia Gravis (MG)	G70.0	☐ Selective deficiency of IgG Subclasses	D80.3
☐ Solid organ transplant recipients at risk for cytomegalovirus infections\pneumonia	B25.9	☐ Specific Antibody Deficiency	D80.6
☐ Stiff Person Syndrome	G25.82	☐ 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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