

Immunoglobulin Prescription Form Please fax completed order form to 614.961.1081

after blood draw

NO Heparin needed

Groshong PICC, Midline

4153 Arlingate Plaza | Suite 4153 | Columbus. OH 43228

OFFICE: 877.378.4063 F	AX: 614 961 1081	<u>Prescription:</u>					
'		☐ Intravenous Immunoglobulin ☐ Subcutaneous Immunoglobul					ulin
<u>Demographic Information:</u>		□ 0.4 gm/kg □1gm/kg □2gm/kg □	grams				
Patient Name Date of Birth		Infuse: IV daily x day(s); repeat every week(s) x cycles					
Home Address		Hydration order:mls NS iv to be infused prior/post IVIGmonths. □ Pre-medications: Acetaminophen 650mg PO 30 mins prior to infusion □ Other Pre-medications: Diphenhydramine 25mg PO 30 mins prior to infusion					
City, State, Zip		Diprientiyurantiine 23ttig FO 30	mins prior to imusion	ı			
Home Phone Mobile or Work Phone Clinical Information: Patient Weight: Height: Allergies:							
Primary Insurance Name		□ IV access [for IVIg patients only]:		□ Nurs	se to place PIV prior to the	erapy	
Primary Insurance ID Primary Insurance Group		Diagnosis	osis ICD-10		Diagnosis		ICD-10
		Neuromuscular:		Immune	e Deficiency:		
Insured Name Insured Date of Birth		☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	G61.81	_	☐ CVID w/ Predominant Immunoregulatory T-Cell Disorders		D83.1
		□ Dermatopolymyositis	M33.90		☐ Combined Immunodeficiency, Unspecified		D81.9
Secondary Insurance Name Insurance ID Insurance Group		☐ 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		nodeficiency with Increased IgM		D80.5
Secondary Insurance ID Secondary Insurance Group		☐ Myasthenia Gravis with (Acute) Exacerbation	G70.01	□ Nonfamilial Hypogammaglobulinemia □ Other combined Immunodeficiencies			D80.1 D81.89
		□ Polymyositis	M33.20	_	Common Variable Immunodeficiencies		D83.9
Ordering Physician's Name		☐ Relapsing Remitting Multiple Sclerosis (RRMS) ☐ Stiff Person Syndrome					L12.0
		Other:	G25.82	☐ Pemphigoid ☐ Pemphigus			L10.9
		☐ Autoimmune Encephalopathy	G04.81		vith Low or Normal B-Cell Numbers		D81.2
Address		☐ Idiopathic Thrombocytopenic Purpura	D69.3	□ SCID with Low T- and B- Cell Numbers			D81.1
		☐ Inflammatory Neuropathies	G61.89		ve deficiency of IgG Subclasses		D80.3
City, State, Zip	_				c Antibody Deficiency		D80.6
				☐ System	nic lupus erythematosus (SLE)		M32.9
Phone	Fax	Please Draw: □ CBC/diff □ CMP □ IgG w/subclasses 1-4 □ □ Frequency:	l □ Quant. Ig	PER Anaphylaxis Protocol: □ Quant. Ig □ Quant. Ig □ Pediatric – 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**			
Please fax the following	information:			liviay repeat	x 1. Order is valid for 1 year]. Use	дененс н аррисар	ie
□ History and Physical □ Pertinent Lab Work		Notes:	If applicable, flush intravenous access device per KabaFusi			n protocol:	
☐ Front & Back copy(s) of patient's insurance card(s)			Access		NS	Heparin	
		<u> </u>	Peripheral		1-3ml before/after use	10u/ml 1-2mls after last NS flush	
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					NS 5-10 mls before/after use; 10mls after blood draw	10 u/ml 3-5mls after last NS flush; 5mls after blood draw	
fills of the same prescription for the patient listed above. I understand that I can			Implanted Port 5-10ml		5-10mls before/after use; 20mls after blood draw	flush; 5mls after blood draw	
revoke this designation at any time by providing written notice to KabaFusion.			Tunneled		5-10mls before/after use; 20mls after blood draw	10 u/ml 3- mls after last NS flush. 5mls after blood draw	
Physician Signature:			Crookens DICC Midling		5-10mls before/after use; 10mls	before/after use; 10mls	

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