KabaFusion FL
Patient-Focused Infusion Therapy

Immune Deficiency Immunoglobulin Therapy Patient Referral and Prescription Sheet

Return Signed RX via Fax to 561.353.4666

To: Liz Magafas, Pharm.D.	From:	Phone:
Intake phone: **561.353.4663**	Fax:	Number of Pages (Including Cover):

Date:	**DOB:**	**Allergies:**

Patient Name:	**Height:**	**Weight:**

Rx: Intravenous Route
IVIG __________ grams daily for ________ day(s) OR IVIG ________ grams/kilogram daily given over ________ non-consecutive day(s)
Repeat course every _____ week(s) for a total of _______ course(s) Dose will be rounded to nearest vial size.

Rx: Subcutaneous Route
IG__________ grams each month given as____________ doses OR IG __________ grams ______ times per month. Administer SQIG using _____________ sites at a time. Repeat __________week(s). Ok to round dose to nearest vial size. Refill x 1yr.

Diagnosis:	**ICD-9**	**ICD-10**
☐ Common Variable Immunodeficiency with Predominant Immunoregulatory T-Cell Disorders	279.10	D83.1
☐ Wiskott-Aldrich Syndrome	279.12	D82.0
☐ Combined Immunodeficiency, Unspecified	279.2	D81.9
☐ Severe Combined Immunodeficiency [SCID] with Low T- and B- Cell Numbers		D81.1
☐ Severe combined Immunodeficiency [SCID]with Low or Normal B-Cell Numbers		D81.2
☐ Selective deficiency of Immunoglobulin A IgA]	279.01	D80.2

Diagnosis:	**ICD-9**	**ICD-10**
☐ Selective deficiency of Immunoglobulin M [IgM]	279.02	D80.4
☐ Selective deficiency of Immunoglobulin G [IgG] Subclasses	279.03	D80.3
☐ Hereditary Hypogammaglobulinemia	279.04	D80.0
☐ Immunodeficiency with Increased IgM	279.05	D80.5
☐ Other Common Variable Immunodeficiencies	279.06	D83.8
☐ Common Variable Immunodeficiency, Unspecified		D83.9
☐ Other:		

IV Access Device: ☐ Peripheral ☐ Central
☐ Hydration: Infuse 500 ml of NS. Start at 100ml/hr 30 minutes before the IVIG starts; then run concurrently with IVIG infusion.

Premedication Orders: Refill x 1Year

☐ **Per Home Care Services recommendation:**
-ACETAMINOPHEN 650 MG (325mg X 2) orally PRE-IVIG
-DIPHENHYDRAMINE 25 MG orally PRE-IVIG
☐ **None**
☐ **Other premed orders:**________________________________
☐ **Other premed orders:**________________________________
☐ **Other premed orders:**________________________________
☐ **Epi-Pen 0.3mg 2-Pak Auto-Injector**

If applicable, flush intravenous access device per Home Care Services protocol:

Access	NS	Heparin 100 u/ml
Peripheral	1 - 3 ml before/after use	1 - 3 ml after last NS
Midline, Central (Non-Port), PICC	3 - 5 ml before/after use 5 - 10 ml after blood draw	3 - 5 ml after last NS
Implanted Port	5 - 10 ml before/after use 10 - 20 ml after blood draw	5 ml after last NS
Groshong PICC, Midline	5 - 10 ml before/after use 10 - 20 ml after blood draw	None

If needed, a Basic Metabolic Panel (Chem 7) to be drawn prior to first dose. If necessary Patient may have first dose administered in the home by a skilled nurse, unless instructed otherwise. Pharmacy to provide all equipment and medical supplies necessary to administer therapy as appropriate.

Prescriber Signature: ______________________________________ Date ______________________________

Print Prescriber Name: _____________________________________ NPI# ______________________________

Please fax the following information:

- ☒ Immunoglobulin order – include dose, route of administration, frequency, duration, and any pre-medications **OR** use prescription order section above
- ☒ Patient demographics – include insurance information. **We will obtain authorization** unless the insurance dictates otherwise
- ☒ H & P **OR** progress note(s) describing diagnosis and clinical status
- ☒ Labs – BUN/Creatinine (preferred within last 90 days), Immunoglobulin Panel

CONFIDENTIALITY NOTICE
The following includes confidential, proprietary information that is the sole exclusive property of KabaFusion Holdings, LLC. No rights in, relating to, or derived from such information are assigned or otherwise transferred by this document, and the recipient of such information is subject to obligations of secrecy to and for the benefit of KabaFusion Holdings, LLC. Any unauthorized use or disclosure of such information is strictly prohibited. This message, together with any attachments, is intended only for the use of the individual or entity to which it is addressed and may contain information that is confidential and prohibited from disclosure. If you are not the intended recipient, you are hereby notified that any dissemination, or copying of this message, or any attachment, is strictly prohibited. If you have received this message in error, please notify the original sender immediately by telephone or by return fax and shred this document along with any other documents. Thank you.

KabaFusion FL | 3500 NW Boca Raton Blvd., Suite 704 | Boca Raton, FL 33431
Phone 561.353.4663 | Fax 561.353.4666 | www.kabafusion.com

*Please be sure to complete fields highlighted in red