KabaFusion
Patient-Focused Infusion Therapy

Cuvitru SCIG Therapy Patient Referral and Prescription Sheet Return Signed RX via Fax to: 888.837.2716

To:	From:	Phone:
Intake Phone:	Fax:	Number of Pages (Including Cover):

Date:	**DOB:**	**Allergies:**
Patient Name:	**Height:**	**Weight:**

☐ Begin Cuvitru_____grams SCIG every_____for_____month

Infusions 1 and 2: maximum 20 ml/hr./site. Subsequent infusions: may increase rate as tolerated to maximum 60 ml/hr./site

KabaFusion to provide infusion pump needle administration sets (A4221)

KabaFusion to provide infusion supplies for infusion pump (A4222)

KabaFusion to provide mechanical ambulatory infusion pump (EO779)

KabaFusion to provide all professional services related to infusion (G0069)

Infusion RN home visit prior to therapy start to assess patient and home environment, educate patient about SCIG therapy as requested by patient.

Infusion RN visits x 3 and PRN to educate patient to self-administer Cuvitru infusion

Diagnosis:	**ICD-10**
☐ Common Variable Immunodeficiency w/ Predominant Immunoregulatory T-Cell Disorders	D83.1
☐ Combined Immunodeficiency, Unspecified	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	D80.2
☐ Antibody deficiency w/near normal immunoglobulins or hyperimmunoglobulinemia	D80.6

Diagnosis:	**ICD-10**
☐ Immunodeficiency w/predominantly antibody defects	D80.9
☐ Selective deficiency of Immunoglobulin M [IgM]	D80.4
☐ Selective deficiency of Immunoglobulin G [IgG] Subclasses	D80.3
☐ Hereditary Hypogammaglobulinemia	D80.0
☐ Immunodeficiency with Increased IgM	D80.5
☐ Other Common Variable Immunodeficiencies	D83.8
☐ Common Variable Immunodeficiency Unspecified	D83.9
☐ Other specific immunodeficiencies	D84.8
☐ Wiskott-Aldrich Syndrome	D82.0
☐ Other:	

Premedication Orders: **Refill x 1Year**

☐ **Per KabaFusion recommendation:**
-ACETAMINOPHEN 650 MG (325mg X 2) orally PRE-SCIG
-DIPHENHYDRAMINE 25 MG orally PRE-SCIG

☐ **None**

☐ **Other premed orders:** _____

☐ **Other premed orders:** _____

☐ **Other premed orders:** _____

☐ **Epinephrine Auto Injector 0.3mg 2-Pak**

☐ **Epinephrine Auto Injector Junior 0.15mg 2-Pak**

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.

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

KabaFusion
www.kabafusion.com

*Please be sure to complete fields highlighted in red