



Cutaquig SCIG Therapy Patient Referral and Prescription Sheet Return Signed RX via Fax to 614.961.1081

To:		From:		Phone:	
Intake phone: 877.378.4063		Fax:		Number of Pages (Including Cover):	
Date:		DOB:		Allergies:	
Patient Name:			Height:		Weight:
<input type="checkbox"/> Begin Cutaquig SCIG per KabaFusion protocol for _____ months <input type="checkbox"/> Begin Cutaquig _____ grams SCIG every _____ for _____ months <input checked="" type="checkbox"/> KabaFusion to provide infusion pump needle administration sets (A4221) <input checked="" type="checkbox"/> KabaFusion to provide infusion supplies for infusion pump (K0552) <input checked="" type="checkbox"/> KabaFusion to provide mechanical ambulatory infusion pump (E0779) <input checked="" type="checkbox"/> Infusion RN home visit prior to therapy start to assess patient and home environment, educate patient about SCIG therapy. <input checked="" type="checkbox"/> Infusion RN visits x 3 and PRN to educate patient to self administer Cutaquig infusion <input checked="" type="checkbox"/> KabaFusion to provide all professional services related to infusion					
Diagnosis:					ICD-10
<input type="checkbox"/> Common Variable Immunodeficiency with Predominant Immunoregulatory T-Cell Disorders					D83.1
<input type="checkbox"/> Wiskott-Aldrich Syndrome					D82.0
<input type="checkbox"/> Combined Immunodeficiency, Unspecified					D81.9
<input type="checkbox"/> Severe Combined Immunodeficiency [SCID] with Low T- and B- Cell Numbers					D81.1
<input type="checkbox"/> Severe combined Immunodeficiency [SCID]with Low or Normal B-Cell Numbers					D81.2
<input type="checkbox"/> Selective deficiency of Immunoglobulin A [IgA]					D80.2
<input type="checkbox"/> Selective deficiency of Immunoglobulin M [IgM]					D80.4
<input type="checkbox"/> Selective deficiency of Immunoglobulin G [IgG] Subclasses					D80.3
<input type="checkbox"/> Hereditary Hypogammaglobulinemia					D80.0
<input type="checkbox"/> Immunodeficiency with Increased IgM					D80.5
<input type="checkbox"/> Other Common Variable Immunodeficiencies					D83.8
<input type="checkbox"/> Common Variable Immunodeficiency, Unspecified					D83.9
<input type="checkbox"/> Other:					
Premedication Orders:			DIPHENHYDRAMINE 25 MG orally PRE-SCIG		
Refill x 1Year			Other: _____		
<input type="checkbox"/> Per KabaFusion recommendation:			<input type="checkbox"/> Epinephrine 0.3mg 2-Pak Auto-Injector		
<input type="checkbox"/> ACETAMINOPHEN 650 MG (325mg X 2) orally PRE-SCIG			<input type="checkbox"/> None		
Prescriber Signature: _____			Date: _____		
Print Prescriber Name: _____			NPI# _____		
Please fax the following information:					
<input checked="" type="checkbox"/> Immunoglobulin order – include dose, route of administration, frequency, duration, and any pre-medications OR use prescription order section above					
<input checked="" type="checkbox"/> Patient demographics – include insurance information. We will obtain authorization unless the insurance dictates otherwise					
<input checked="" type="checkbox"/> H & P OR progress note(s) describing diagnosis and clinical status					
<input checked="" type="checkbox"/> Labs – BUN/Creatinine (preferred within last 90 days), Immunoglobulin Panel					
<small>CONFIDENTIALITY NOTICE</small>					
<small>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.</small>					
KabaFusion Infusion Pharmacy 4153 Arlingate Plaza Suite 4153 Columbus, OH 43228					
Phone: 877.378.4063 Fax: 614.961.1081 www.kabafusion.com					

*Please be sure to complete fields highlighted in red