



Cutaquig SCIG Therapy Patient Referral and Prescription Sheet Return Signed RX via Fax to 407.425.7445

To:		From:		Phone:	
Intake phone: 407.425.7114		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>					
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*Please be sure to complete fields highlighted in red