



Cutaquig SCIG Therapy Patient Referral and Prescription Sheet Return Signed RX via Fax to 704.583.2130

To:	From:	Phone:
Intake phone: 704.583.2140	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: Refill x 1Year <input type="checkbox"/> Per KabaFusion recommendation: <input type="checkbox"/> ACETAMINOPHEN 650 MG (325mg X 2) orally PRE-SCIG		DIPHENHYDRAMINE 25 MG orally PRE-SCIG Other: _____ <input type="checkbox"/> Epinephrine 0.3mg 2-Pak Auto-Injector <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		
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*Please be sure to complete fields highlighted in red