

Immune Deficiency Immunoglobulin 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:															
Rx: Intravenous Route IVIG _____ grams daily for _____ day(s) OR IVIG _____ grams/kilogram daily given over _____ non-consecutive/ 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	Diagnosis:																
<input type="checkbox"/> Common Variable Immunodeficiency with Predominant Immunoregulatory T-Cell Disorders		279.10	D83.1	<input type="checkbox"/> Selective deficiency of Immunoglobulin M [IgM]																
<input type="checkbox"/> Wiskott-Aldrich Syndrome		279.12	D82.0	<input type="checkbox"/> Selective deficiency of Immunoglobulin G [IgG] Subclasses																
<input type="checkbox"/> Combined Immunodeficiency, Unspecified		279.2	D81.9	<input type="checkbox"/> Hereditary Hypogammaglobulinemia																
<input type="checkbox"/> Severe Combined Immunodeficiency [SCID] with Low T- and B- Cell Numbers			D81.1	<input type="checkbox"/> Immunodeficiency with Increased IgM																
<input type="checkbox"/> Severe combined Immunodeficiency [SCID]with Low or Normal B-Cell Numbers			D81.2	<input type="checkbox"/> Other Common Variable Immunodeficiencies																
<input type="checkbox"/> Selective deficiency of Immunoglobulin A [IgA]		279.01	D80.2	<input type="checkbox"/> Common Variable Immunodeficiency, Unspecified																
				<input type="checkbox"/> Other:																
IV Access Device: <input type="checkbox"/> Peripheral <input type="checkbox"/> Central <input type="checkbox"/> 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			If applicable, flush intravenous access device per KabaFusion protocol:																	
<input type="checkbox"/> Per KabaFusion recommendation: -ACETAMINOPHEN 650 MG (325mg X 2) orally PRE-IVIG -DIPHENHYDRAMINE 25 MG orally PRE-IVIG			<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Access</th> <th>NS</th> <th>Heparin 100 u/ml</th> </tr> </thead> <tbody> <tr> <td>Peripheral</td> <td>1 - 3 ml before/after use</td> <td>1 - 3 ml after last NS</td> </tr> <tr> <td>Midline, Central (Non-Port), PICC</td> <td>3 - 5 ml before/after use 5 - 10 ml after blood draw</td> <td>3 - 5 ml after last NS</td> </tr> <tr> <td>Implanted Port</td> <td>5 - 10 ml before/after use 10 - 20 ml after blood draw</td> <td>5 ml after last NS</td> </tr> <tr> <td>Groshong PICC, Midline</td> <td>5 - 10 ml before/after use 10 - 20 ml after blood draw</td> <td>None</td> </tr> </tbody> </table>			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
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																		
<input type="checkbox"/> None <input type="checkbox"/> Other premed orders: _____ <input type="checkbox"/> Other premed orders: _____ <input type="checkbox"/> Other premed orders: _____ <input type="checkbox"/> Epi-Pen 0.3mg 2-Pak Auto-Injector																				
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:																				
<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																				
CONFIDENTIALITY NOTICE																				
<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 13504 S Point Blvd. Suite H Charlotte, NC 28273																				
Phone: 704.583.2140 Fax: 704.583.2130 www.kabafusion.com																				

*Please be sure to complete fields highlighted in red