

## Immune Deficiency Immunoglobulin Therapy Patient Referral and Prescription Sheet

### Return Signed RX via Fax to: 757.424.5871

To:		From:		Phone:																
Intake phone: <b>757.424.4822</b>		Fax:		Number of Pages (Including Cover):																
<b>Date:</b>		<b>DOB:</b>		<b>Allergies:</b>																
<b>Patient Name:</b>			<b>Height:</b>		<b>Weight:</b>															
<b>Rx: Intravenous Route</b> 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.																				
<b>Rx: Subcutaneous Route</b> 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.																				
<b>Diagnosis:</b>		<b>ICD-9</b>	<b>ICD-10</b>	<b>Diagnosis:</b>																
<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:																
<b>IV Access Device:</b> <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.																				
<b>Premedication Orders:</b> Refill x 1Year			<b>If applicable, flush intravenous access device per KabaFusion protocol:</b>																	
<input type="checkbox"/> <b>Per KabaFusion recommendation:</b> <b>-ACETAMINOPHEN 650 MG (325mg X 2) orally          PRE-IVIG</b> <b>-DIPHENHYDRAMINE 25 MG orally PRE-IVIG</b> <input type="checkbox"/> <b>None</b> <input type="checkbox"/> <b>Other premed orders:</b> _____ <input type="checkbox"/> <b>Other premed orders:</b> _____ <input type="checkbox"/> <b>Other premed orders:</b> _____ <input type="checkbox"/> <b>Epi-Pen 0.3mg 2-Pak Auto-Injector</b>			<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
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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 <b>OR</b> use prescription order section above																				
<input checked="" type="checkbox"/> Patient demographics – include insurance information. <b>We will obtain authorization</b> unless the insurance dictates otherwise																				
<input checked="" type="checkbox"/> H & P <b>OR</b> progress note(s) describing diagnosis and clinical status																				
<input checked="" type="checkbox"/> Labs – BUN/Creatinine (preferred within last 90 days), Immunoglobulin Panel																				
<b>CONFIDENTIALITY NOTICE</b>																				
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<b>KabaFusion Infusion Pharmacy   816 Greenbrier Cir.   Suite E   Chesapeake, VA 23320</b> <b>Phone: 757.424.4822   Fax: 757.424.5871   www.kabafusion.com</b>																				

\*Please be sure to complete fields highlighted in red