

## Immune Deficiency Immunoglobulin Therapy Patient Referral and Prescription Sheet

### Return Signed RX via Fax to: 833.543.0292

| To:   |   | From:                  |  | Phone:  |                |        |    |                  |            |                           |                        |                                      |   |                        |                |   |                    |                           |   |      |
|---|---|------------------------|--|---|----------------|--------|----|------------------|------------|---------------------------|------------------------|--------------------------------------|---|------------------------|----------------|---|--------------------|---------------------------|---|------|
| Intake phone: <b>855.434.4844</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><br>IVIG _____ grams daily for _____ day(s) OR IVIG _____ grams/kilogram daily given over _____ non-consecutive/<br>consecutive day(s)<br>Repeat course every _____ week(s) for a total of _____ course(s) Dose will be rounded to nearest vial size.   |   |                        |  |   |                |        |    |                  |            |                           |                        |                                      |   |                        |                |   |                    |                           |   |      |
| <b>Rx: Subcutaneous Route</b><br>IG _____ grams each month given as _____ doses OR IG _____ grams _____ times per month. Administer SQIG<br>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<br>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<br>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]<br>with Low T- and B- Cell Numbers   |   |                        | D81.1  | <input type="checkbox"/> Immunodeficiency with Increased IgM                          |                |        |    |                  |            |                           |                        |                                      |   |                        |                |   |                    |                           |   |      |
| <input type="checkbox"/> Severe combined Immunodeficiency<br>[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,<br>Unspecified             |                |        |    |                  |            |                           |                        |                                      |   |                        |                |   |                    |                           |   |      |
|   |   |                        |  | <input type="checkbox"/> Other:   |                |        |    |                  |            |                           |                        |                                      |   |                        |                |   |                    |                           |   |      |
| <b>IV Access Device:</b> <input type="checkbox"/> Peripheral <input type="checkbox"/> Central<br><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><br><b>-ACETAMINOPHEN 650 MG (325mg X 2) orally PRE-IVIG</b><br><b>-DIPHENHYDRAMINE 25 MG orally PRE-IVIG</b><br><input type="checkbox"/> <b>None</b><br><input type="checkbox"/> <b>Other premed orders:</b> _____<br><input type="checkbox"/> <b>Other premed orders:</b> _____<br><input type="checkbox"/> <b>Other premed orders:</b> _____<br><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,<br/>Central (Non-Port), PICC</td> <td>3 - 5 ml before/after use<br/>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<br/>10 - 20 ml after blood draw</td> <td>5 ml after last NS</td> </tr> <tr> <td>Groshong PICC,<br/>Midline</td> <td>5 - 10 ml before/after use<br/>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,<br>Central (Non-Port), PICC | 3 - 5 ml before/after use<br>5 - 10 ml after blood draw | 3 - 5 ml after last NS | Implanted Port | 5 - 10 ml before/after use<br>10 - 20 ml after blood draw | 5 ml after last NS | Groshong PICC,<br>Midline | 5 - 10 ml before/after use<br>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,<br>Central (Non-Port), PICC  | 3 - 5 ml before/after use<br>5 - 10 ml after blood draw   | 3 - 5 ml after last NS |  |   |                |        |    |                  |            |                           |                        |                                      |   |                        |                |   |                    |                           |   |      |
| Implanted Port  | 5 - 10 ml before/after use<br>10 - 20 ml after blood draw | 5 ml after last NS     |  |   |                |        |    |                  |            |                           |                        |                                      |   |                        |                |   |                    |                           |   |      |
| Groshong PICC,<br>Midline   | 5 - 10 ml before/after use<br>10 - 20 ml after blood draw | None                   |  |   |                |        |    |                  |            |                           |                        |                                      |   |                        |                |   |                    |                           |   |      |
| 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   |   |                        |  |   |                |        |    |                  |            |                           |                        |                                      |   |                        |                |   |                    |                           |   |      |
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| <b>KabaFusion Infusion Pharmacy   5860 W. Las Positas Blvd   Suite 19   Pleasanton, CA 94588</b><br><b>Phone: 855.434.4844   Fax: 833.543.0292   www.kabafusion.com</b>   |   |                        |  |   |                |        |    |                  |            |                           |                        |                                      |   |                        |                |   |                    |                           |   |      |

\*Please be sure to complete fields highlighted in red