



Cutaquig SCIG Therapy Patient Referral and Prescription Sheet Return Signed RX via Fax to 877.239.8117

To:	From:	Phone:
Intake phone: 609.567.2241	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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KabaFusion Infusion Pharmacy 129 N. White Horse Pike Suite 1 Hammonton, NJ 08037 Phone: 609.567.2241 Fax: 877.239.8117 www.kabafusion.com		

*Please be sure to complete fields highlighted in red