KabaFusion
Patient-Focused Infusion Therapy

Immune Deficiency Immunoglobulin Therapy Patient Referral and Prescription Sheet

Return Signed RX via Fax to: 877.445.8821

To:	From:	Phone:
Intake phone: **877.577.4844**	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
☐ Common Variable Immunodeficiency with Predominant Immunoregulatory T-Cell Disorders	279.10	D83.1
☐ Wiskott-Aldrich Syndrome	279.12	D82.0
☐ Combined Immunodeficiency, Unspecified	279.2	D81.9
☐ Severe Combined Immunodeficiency [SCID] with Low T- and B- Cell Numbers		D81.1
☐ Severe combined Immunodeficiency [SCID]with Low or Normal B-Cell Numbers		D81.2
☐ Selective deficiency of Immunoglobulin A IgA]	279.01	D80.2

Diagnosis:	ICD-9	ICD-10
☐ Selective deficiency of Immunoglobulin M [IgM]	279.02	D80.4
☐ Selective deficiency of Immunoglobulin G [IgG] Subclasses	279.03	D80.3
☐ Hereditary Hypogammaglobulinemia	279.04	D80.0
☐ Immunodeficiency with Increased IgM	279.05	D80.5
☐ Other Common Variable Immunodeficiencies	279.06	D83.8
☐ Common Variable Immunodeficiency, Unspecified		D83.9
☐ Other:		

IV Access Device: ☐ Peripheral ☐ Central

☐ 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

☐ **Per KabaFusion recommendation:**
-ACETAMINOPHEN 650 MG (325mg X 2) orally PRE-IVIG
-DIPHENHYDRAMINE 25 MG orally PRE-IVIG

☐ **None**

☐ **Other premed orders:**_____

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☐ **Other premed orders:**_____

☐ **Epi-Pen 0.3mg 2-Pak Auto-Injector**

If applicable, flush intravenous access device per KabaFusion protocol:

Access	NS	Heparin
Peripheral	1 - 3 ml before/after use	Heparin 10 u/ml 1 - 3 ml after last NS
Midline, Central (Non-Port), PICC	3 - 5 ml before/after use 5 - 10 ml after blood draw	Heparin 10 u/ml 3 - 5 ml after last NS
Implanted Port	5 - 10 ml before/after use 10 - 20 ml after blood draw	Heparin 100 u/ml 5 ml after last NS
Groshong PICC, Midline	5 - 10 ml before/after use 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:

- ☒ Immunoglobulin order – include dose, route of administration, frequency, duration, and any pre-medications **OR** use prescription order section above
- ☒ Patient demographics – include insurance information. **We will obtain authorization** unless the insurance dictates otherwise
- ☒ H & P **OR** progress note(s) describing diagnosis and clinical status
- ☒ Labs – BUN/Creatinine (preferred within last 90 days), Immunoglobulin Panel

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*Please be sure to complete fields highlighted in red