KabaFusion
Patient-Focused Infusion Therapy

Cutaquig SCIG Therapy Patient Referral and Prescription Sheet Return Signed RX via Fax to 207.810.2372

To:	From:	Phone:
Intake phone: **877.373.1523**	Fax:	Number of Pages (Including Cover):

Date:	**DOB:**	**Allergies:**
Patient Name:	**Height:**	**Weight:**

☐ Begin Cutaquig SCIG per KabaFusion protocol for_____months
☐ Begin Cutaquig_____grams SCIG every_____for_____months
☒ KabaFusion to provide infusion pump needle administration sets (A4221)
☒ KabaFusion to provide infusion supplies for infusion pump (K0552)
☒ KabaFusion to provide mechanical ambulatory infusion pump (E0779)
☒ Infusion RN home visit prior to therapy start to assess patient and home environment, educate patient about SCIG therapy.
☒ Infusion RN visits x 3 and PRN to educate patient to self administer Cutaquig infusion
☒ KabaFusion to provide all professional services related to infusion

Diagnosis:	ICD-10
☐ Common Variable Immunodeficiency with Predominant Immunoregulatory T-Cell Disorders	D83.1
☐ Wiskott-Aldrich Syndrome	D82.0
☐ Combined Immunodeficiency, Unspecified	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]	D80.2
☐ Selective deficiency of Immunoglobulin M [IgM]	D80.4
☐ Selective deficiency of Immunoglobulin G [IgG] Subclasses	D80.3
☐ Hereditary Hypogammaglobulinemia	D80.0
☐ Immunodeficiency with Increased IgM	D80.5
☐ Other Common Variable Immunodeficiencies	D83.8
☐ Common Variable Immunodeficiency, Unspecified	D83.9
☐ Other:	

Premedication Orders:
Refill x 1Year
☐ Per KabaFusion recommendation:
☐ ACETAMINOPHEN 650 MG (325mg X 2) orally PRE-SCIG
DIPHENHYDRAMINE 25 MG orally PRE-SCIG
Other: _____
☐ Epinephrine 0.3mg 2-Pak Auto-Injector
☐ None

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