TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

IVIG

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: ______ DOB: ______	Prescriber Name: ______
Address: ______	State License: ______
City, State, Zip: ______	NPI #: ______ Tax ID: ______
Phone: ______ Alt. Phone: ______	Address: ______
Email: ______ SS#: ______	City, State, Zip: ______
Gender: ☐ M ☐ F Weight: ______(lbs) Ht: ______	Phone: ______ Fax: ______
Allergies: ______	Office Contact: ______ Phone: ______

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary	Secondary
Primary Insurance: ______	Secondary Insurance (If Applicable): ______
Plan #: ______	Plan #: ______
Group #: ______	Group #: ______
RX Card (PBM): ______	RX Card (PBM): ______
BIN: ______ PCN: ______	BIN: ______ PCN: ______

CLINICAL INFORMATION

☐ D80 Immunodeficiency with predominantly antibody defects	☐ D80.1 Nonfamilial hypogammaglobulinemia	☐ D80.3 Selective deficiency of immunoglobulin G [IgG] subclasses	☐ D83.9 Common variable immunodeficiency (unspecified)
☐ G35 Multiple Sclerosis	☐ G61.0 Guillain-Barré Syndrome	☐ G61.81 CIDP	☐ G61.82 Multifocal motor neuropathy
☐ G70.00 Myasthenia gravis	☐ G70.01 Myasthenia Gravis with (acute) exacerbation	☐ M33.10 Other dermatomyositis, organ involvement unspecified	☐ M33.22 Polymyositis with myopathy
☐ M33.12 Dermatomyositis with myopathy	☐ Other: ______		

Vascular access: ☐ Peripheral ☐ Central ☐ Port Infusion method: ☐ Gravity ☐ Pump

Adverse Reactions with Previous IG treatments? ☐ No ☐ Yes Reason/Brand: ______

TRIED AND/OR FAILED MEDICATIONS	LEGNTH OF THERAPY	REASON FOR DISCONTINUATION
______ /	______ /	______
______ /	______ /	______

IVIG ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: ______ Date of Last Injection/Infusion: ______

Medication			Dose/Frequency	Refills
☐ Asceniv™ 10%	☐ Bivigam® 10%	☐ Gammagard® liquid 10%	☐ Infuse ______ grams intravenously every ______ weeks.	______
☐ Gammagard® S/D 5%	☐ Gammagard® S/D 10%	☐ Gammaked™ 10%	☐ Infuse ______ g/kg intravenously every ______ weeks.	
☐ Gamunex®-C 10%	☐ Octagam® 5%	☐ Octagam® 10%	☐ Infuse ______ mg/kg intravenously every ______ weeks.	
☐ Panzyga® 10%	☐ Privigen® 10%	☐ Non-Branded	☐ Other: ______	

Pre-Medication	Dose/Strength	Directions
☐ Acetaminophen	☐ 500mg	☐ Take 1-2 tablets PO prior to infusion or post-infusion as directed
☐ Diphenhydramine	☐ 25mg IV/PO ☐ 50mg IV/PO	☐ Take 1 tablet PO prior to infusion or as directed OR ☐ Inject contents of 1 vial IV prior to infusion or as directed
☐ Methylprednisolone	☐ 40mg ☐ 125mg	☐ Inject contents of 1 vial IV prior to infusion or as directed

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☐ Sodium Chloride 0.9%	☐ 500 mL	☐ Infuse 500mL prior to each infusion or as directed
☐ ____________________	____________________	____

INFUSION REACTION ORDERS

Mild reaction protocol:

☒ Diphenhydramine 25mg IV, one time, for pruritus.

If symptoms worsen, see orders for moderate to severe reactions.

Moderate reaction protocol:

☒ Acetaminophen 650mg PO, one time, for pyrexia or rigors

☒ Diphenhydramine 50mg IV, one time, for pruritus or urticaria

☒ Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms

If symptoms worsen, see interventions for severe reactions

Severe reaction protocol: (Call 911 if initiated):

☒ Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)

☒ Diphenhydramine 50mg IV,one time, for respiratory symptoms, edema, or anaphylaxis

☒ Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis

☒ Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms

☒ Epinephrine 0.3mg/0.3mL IM into mis-anterolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen

FLUSHING & LOCKING ORDERS

Flushing Protocol (>66lbs/33kg)

PIV and Midline:	**Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:**
☒ 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion	☒ 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw

Locking Protocol (>66lbs/33kg)

PIV and Midline:	**PICC:**	**Implanted Port, Tunneled Catheter, and Non-tunneled Catheter:**
☒ Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush	☒ Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush	☒ Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush

**** May substitute Dextrose 5% in Water, or alternative, for 0.9& Sodium Chloride, when indicated due to incompatibility with medications bring infused**

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X____ Date: ____________________

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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