



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)) PRE	RESCRIBER INFORMATION			
Name: DOB:		Preso	rescriber Name:			
Address:		State	State License:			
City, State, Zip:		NPI #	NPI #: Tax ID:			
Phone: Alt. Phone:			Address:			
Email: SS#:			City, State, Zip:			
Gender: M F Weight:(lbs) Ht:			Phone: Fax:			
Allergies:			ffice Contact: Phone:			
INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)						
Primary Insurance:			econdary Insurance (If Applicable):			
Plan #:			Plan #:			
Group #:			roup #:			
RX Card (PBM):		RX C	RX Card (PBM):			
BIN:			PCN:			
CLINICAL INFORMATION						
☐ J82.83 Severe Eosinophilic Asthma ☐ L50.1 Chronic Idiopathic Urticaria ☐ Other:						
Prior Anaphylactic Reaction: ☐ No ☐ Yes (Reason/Date):						
Lab Results:						
	al Aeroallergen: 🗆 Yes 🗀 No	Test Date:				
Positive Skin or RAST test to Perennial Aeroallergen: Yes No Test Date:						
Serum Eosinophil Level:						
Sputum Eosinophiles	cells/ffict	rest bate.				
XOLAIR® ORDERS Prescription type: New start Restart Continued therapy Total Doses Received: Date of Last Injection/Infusion: Date of Last Injection/Infusion: New Start Restart Restart Date of Last Injection/Infusion: Date of Last Injection/						
		Total Doses				
Medication	Dose/Frequency		Refills			
☐ Xolair® (omalizumab) 75mg	☐ Injectmg SQ every 2 weeks ☐ Injectmg SQ every 4 weeks		☐ 1-month supply			
☐ Xolair® (omalizumab) 150mg			Other:			
Pre-Medication	Dose/Strength		Refills: Directions			
☐ Acetaminophen	□ 500mg		☐ Take 1-2 tablets PO prior to infusion or post-infusion as directed			
☐ Diphenhydramine	☐ 25mg IV/PO		☐ Take 1 tablet PO prior to infusion or as directed OR			
	☐ 50mg IV/PO		☐ Inject contents of 1 vial IV prior to infusion or as directed			
☐ Methylprednisolone	☐ 40mg ☐ 100mg		☐ Inject contents of 1 vial IV prior to infusion or as directed			
	□ 125mg		☐ Other: Inject 100mg IV 30 minutes prior to infusion			
INFUSION REACTION ORDERS						
Mild reaction protocol:						
☐ Diphenhydramine 25mg IV, one time, for pruritus.						
If symptoms worsen, see orders for moderate to severe reactions.						

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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 re	eactions					
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 re	spiratory symptoms, edem	na, or anaphylaxis				
⊠ Sodium Chloride 0.9% 500mL IV over 30-60 min	n, one time, for cardiovascu	ılar 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 an	d 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-			
☐ Heparin Sodium 10 units/mL 1mL IV final	⋈ Heparin Sodium 10 units/mL 3mL IV final		tunneled Catheter:			
flush post normal saline flush	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, w	hen indicated due to incon	patibility with medications bring infused			
SIGNATURE						
We hereby authorize Talis Healthcare LLC to provious medicine as prescribed in this referral.	de all supplies and addition	nal services (nursing/pati	ent training) required to provide and deliver the			

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.

Prescriber Signature

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