



## 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)		t) PRESCRIBER INFORMATION	PRESCRIBER INFORMATION	
Name:	DOB:	Prescriber Name:	Prescriber Name:	
Address:		State License:	State License:	
City, State, Zip:			NPI #: DEA:	
Phone: Alt. Phone:			Address:	
Email:	SS#:		City, State, Zip:	
Gender:   M   F   Weight:(lbs)   Ht:				
Allergies:		Office Contact: Ph	one:	
INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)				
Primary Insurance:		Secondary Insurance (If Applicable):	Secondary Insurance (If Applicable):	
Plan #:		Plan #:		
Group #:		Group #:		
RX Card (PBM):				
BIN: P	CN:	BIN: PCN:		
CLINICAL INFORMATION				
☐ J45.50 Severe persistent asthma, un	complicated 🗆 J45.51 Sever	re persistent asthma with (acute) exacerbation $\Box$ J82.8	33 Eosinophilic asthma	
☐ J33.0 Polyp of the nasal cavity ☐ M30.1 Polyarteritis with lung involvement [Churg-Strauss] ☐ Other:				
Prior Anaphylactic Reaction: ☐ No ☐ Y	es (Reason/Date):			
Other Medications:				
Lab Results:				
Positive Skin or RAST test to Perennial Aeroallergen:   Yes No Test Date:				
Serum IgE Level	IU/ML	Test Date:		
Serum Eosinophil Level:		Test Date:		
Sputum Eosinophiles				
NUCALA® ORDERS				
Prescription type: ☐ New start ☐ I	Restart	py Total Doses Received: Date of Last	Injection:	
Medication		Directions	Quantity/Refills	
☐ Nucala (mepolizumab) 100mg/mL	☐ Inject 100mg under the skin once every 4 weeks.			
	☐ Inject 300mg (3 separate	100mg injections) under the skin once every 4 weeks.	Quantity:	
	Other:		Refills:	
Pre-Medication	Dose/Strength	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	$\square$ 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	$\square$ Other: Inject 100mg IV 30 minutes prior to infusion		
INFLISION REACTION ORDERS				

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Mild reaction protocol:					
☑ Diphenhydramine 25mg IV, one time, for prurit	tus.				
If symptoms worsen, see orders for moderate to se	evere 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 i	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	n, one time, for cardiovascu	ular 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	nd 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	e, for 0.9& Sodium Chloride, w	vhen indicated due to incom	patibility with medications bring infused		
SIGNATURE					
We hereby authorize Talis Healthcare LLC to provi	ide all supplies and addition	nal services (nursing/pation	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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