



Please Fax Completed Form To: 888-898-9113

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

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PATIENT INFORMAT	ION (Co	mplete or F	ax Existing Cha	PRESCRIBER INFORMATION					
Name:	Name: DOB:					Prescriber Name:			
Address:					State License:				
City, State, Zip:					NPI #: DEA:				
Phone:		Alt. Phone:							
Email:		SS#:							
Gender: M F Weight:(lbs) Ht:						Fax:			
Allergies:					Office Contact:	Phone:			
INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)									
Primary Insurance:					RX Card (PBM):				
City, State, Zip:					BIN: PCN:				
Plan #:									
Group #:					Group #:				
	Phone:					Phone:			
CLINICAL INFORMAT									
☐ K51.90 Moderate to Se		erative Colitis			*If PPD test results are not within 12 months, please perform PPD.				
☐ K50.90 Moderate to Severe Groenan's Disease					Tuberculosis Screening: PPD Test Date:				
☐ M06.9 Rheumatoid Arthritis									
☐ M45.9 Ankylosing Spondylitis					Results: Negative				
☐ L40.52 Psoriatic Arthritis					☐ Positive → ☐ Chest X-Ray Performed Date:				
☐ L40.0 Plague Psoriasis	5				X-Ray Results: ☐ Negative				
·					\square Positive $ o$ TB treatment Initiated				
Other: Labs:									
	MD a.	□ c r	RP at	ECD a.	□ LET¢ α·	□ Y-Ray: □ Other:			
□ CBC q: □ CMP q: □ CRP q: □ ESR q: □ LFTs q: □ X-Ray: □ Other:									
REMICADE®	<u> </u>				T. 10 0 1				
Prescription type: Nev	w start	Restart			Total Doses Received:	Date of Last Infusion:			
Medication			Direct	ions		Quantity/Refills			
Remicade® (infliximab)	Loading dose: 5mg/kg mg IV at w				ek: 0, 2, 6 Loading dose: 3 doses. No refills. Maintenance dose: 8-week supply. Refill				
	☐ 3mg/kg mg IV at v					year unless noted otherwise.			
					cck. 0, 2, 0	week supply			
	Other:					Refill x 1 year unless noted otherwise.			
	☐ Maintenance dose: (mg/kg)			;)	_ mg IV every weeks	☐ Other:			
Pre-Medication	tion Dose/Strength				Directions				
☐ Acetaminophen	□ 500mg			☐ Take 1-2 tablets PO prior to infusion or post-infusion as directed					
		☐ 25mg IV/PO			☐ Take 1 tablet PO prior to infusion or as directed OR				
☐ Diphenhydramine	□ 50mg IV/PO			☐ Inject contents of 1 vial IV prior to infusion or as directed					
		☐ 40mg 100mg			☐ Inject contents of 1 vial IV prior to infusion or as directed				
☐ Methylprednisolone		☐ 125mg			☐ Other: Inject 100mg IV 30 minutes prior to infusion				
INFUSION REACTION ORDERS									
Mild reaction protocol:									

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Date:

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☑ Diphenhydramine 25mg IV, one time, for pruritus.									
If symptoms worsen, see orders for moderate to se	vere 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:							
oxtimes 0.9% Sodium Chloride 2-5mL IV flush before and	d after each infusion	\boxtimes 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		nits/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 incom	patibility with medications bring infused						
SIGNATURE									
We hereby authorize Talis Healthcare LLC to provio medicine as prescribed in this referral	de all supplies and additior	nal services (nursing/patie	nt 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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