



## Please Fax Completed Form To: 888-898-9113

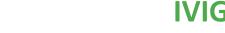
Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Com	plete or Fax Ex	isting 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:					
Allergies:			Office Contact: Phone:					
INSURANCE INFORMATION –	AND – Send a c	opy of the patie	nt's prescription/insurance card	ds (front & back)				
Primary Insurance:			Secondary Insurance (If Applicable):					
Plan #:			Plan #:					
Group #:			Group #:					
RX Card (PBM):			RX Card (PBM):					
BIN: PCN:				N: PCN:				
CUNICAL INFORMATION								
CLINICAL INFORMATION								
□ D80 Immunodeficiency with □ D80.1 Nonfamilial			□ D83.9 Common variable					
predominantly antibody defects hypogammaglobulinemia				immunoglobulin G [IgG] subclasses immunodeficiency (unspecified)				
☐ G35 Multiple Sclerosis ☐ G61.0 Guillain-Barré Syndrome ☐ G70.00 Myasthenia gravis ☐ G70.01 Myasthenia Gravis with				☐ G61.81 CIDP ☐ G61.82 Multifocal motor neuropathy ☐ M33.2 Polymyositis ☐ M33.90 Dermatomyositis				
(acute) exacerbation								
☐ M33.10 Other dermatomyositis, organ	involvement unspeci	fied	☐ Other:					
Vascular access: ☐ Peripheral ☐ C	entral 🗌 Port	Infusion method:	☐ Gravity ☐ Pump					
Adverse Reactions with Previous IG t	reatments?   No	☐ Yes Reason/Bra	nd:					
TRIED AND/OR FAILED MEDICATIONS LEGNTH OF THERAPY REASON FOR DISCONT								
		/						
IVIG ORDERS								
Prescription type: $\square$ New start $\square$ I	Restart   Continu	ued therapy Total	Doses Received: Date or	f Last Injection/Infusion:				
IV	edication		Dose/Frequency					
☐ Asceniv <sup>™</sup> 10% ☐ Bivigam® 10% ☐ Gammagard® liquid 10			%	☐ Infuse grams intravenously every weeks.				
		Gammaked™ 10%		/kg intravenously every				
☐ Gamunex®-C 10% ☐ Octagam® 5% ☐ Octagam® 10% ☐ Panzyga® 10% ☐ Privigen® 10% ☐ Non-Branded				☐ Infuse mg/kg intravenously every weeks. ☐ Other:				
Pre-Medication	Route	Dose	Directions	Quantity	Refills			
☐ Acetaminophen	□ РО	☐ 325mg ☐ 500m		☐ With Each Infusion	#:			
	☐ IV (ofirmev)	☐ Other:	Other:	☐ Other:				
☐ Diphenhydramine	□ PO	□ 25mg □ 50mg		☐ With Each Infusion	#:			
	□IV	Other:		Other:				
☐ Other:					#:			
Other:IV Fluids		· <u> </u>	Directions		#:			
IV Fluids	Route	Dose	Directions	Quantity	#:			
		· <u>-</u>	Directions  Before and after infusion Other:					

CONFIDENTIALITY STATEMENT: This facsimile and documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender at the address and telephone number set forth herein and arrange for return or destruction of the material. In no event should such material be read by anyone other than the named addressee. except by express authority of the sender to the named addressee.



TALIS HEALTHCARE



## Please Fax Completed Form To: 888-898-9113

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

☐ Other:					#:				
Flush	Route	Dose	Directions	Quantity	Refills				
☐ Normal Saline 0.9%	□ IV	☐ 3 mL ☐ 5mL ☐ 10mL	☐ Before and after infusion ☐ Other:	☐ With Each Infusion☐ Other:	#:				
☐ Heparin 10 units/ml ☐ Heparin 100 units/ml	□ IV	☐ 3 mL ☐ 5mL ☐ 10mL	☐ After infusion ☐ Other:	☐ With Each Infusion ☐ Other:	#:				
Anaphylaxis	Route	Dose	Directions	Quantity	Refills				
☐ Diphenhydramine	□ IV □ PO □ IM	☐ 25mg ☐ 50mg ☐ Other:	☐ Pre-Med:	☐ With Each Infusion☐ Other:	#:				
☐ Epinephrine	□ IM □ SQ	☐ Adult: 0.3mL (0.3mg) ☐ Peds: 0.15mL (0.15mg)	☐ PRN Anaphylaxis ☐ Repeating Dose:	☐ Once ☐ Other:	#:				
☐ Other:					#:				
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.

CONFIDENTIALITY STATEMENT: This facsimile and documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender at the address and telephone number set forth herein and arrange for return or destruction of the material. In no event should such material be read by anyone other than the named addressee. except by express authority of the sender to the named addressee.