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)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____
NPI #: _____ Tax ID: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Office Contact: _____ Phone: _____

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

Primary Insurance: _____
Plan #: _____
Group #: _____
RX Card (PBM): _____
BIN: _____ PCN: _____

Secondary Insurance (If Applicable): _____
Plan #: _____
Group #: _____
RX Card (PBM): _____
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
☐ M33.2 Polymyositis
☐ M33.90 Dermatomyositis
☐ M33.10 Other dermatomyositis, organ involvement unspecified
☐ 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
☐ 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	Route	Dose	Directions	Quantity	Refills
☐ Acetaminophen	☐ PO ☐ IV (ofirmev)	☐ 325mg ☐ 500mg ☐ Other: _____	☐ Pre-Med: _____ ☐ Other: _____	☐ With Each Infusion ☐ Other: _____	#: _____
☐ Diphenhydramine	☐ PO ☐ IV	☐ 25mg ☐ 50mg ☐ Other: _____	☐ Pre-Med: _____ ☐ PRN Reaction: _____	☐ With Each Infusion ☐ Other: _____	#: _____
☐ Other: _____	_____	_____	_____	_____	#: _____
IV Fluids	**Route**	**Dose**	**Directions**	**Quantity**	**Refills**
☐ Normal Saline 0.9% ☐ ½ Normal Saline 0.45% ☐ Dextrose 5%	☐ IV	_____	☐ Before and after infusion ☐ Other: _____	☐ With Each Infusion ☐ Other: _____	#: _____

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☐ 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: _____ ☐ Other: _____	☐ 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.