



Please Fax Completed Form To: 888-898-9113

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PATIENT INFORMATION (Complete or Fax Existing Chart)				PRESCRIBER INFORMATION				
Name: DOB:								
Address:				State License:				
City, State, Zip:				NPI #: DEA:				
Phone: Alt. Phone:				Address:				
Email: SS#:				City, State, Zip:				
Gender: ☐ M ☐ F We	ight:	(lbs) Ht:		Phone: Fax: Phone:				
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 #:				City, State, Zip:				
Group #:			'	Group #:				
Phone:				Phone:				
CLINICAL INFORMATION								
☐ K51.90 Moderate to Sev	ere Ulce	rative Colitis		*If PPD test results are not within 12 months, please perform PPD.				
☐ K50.90 Moderate to Severe Crohn's Disease				Tuberculosis Screening: PPD Test Date:				
☐ M06.9 Rheumatoid Arthritis				Results: Negative				
☐ M45.9 Ankylosing Spondylitis				☐ Positive → ☐ Chest X-Ray Performed Date:				
☐ L40.52 Psoriatic Arthritis								
☐ L40.0 Plaque Psoriasis				X-Ray Results: Negative				
☐ Other:				☐ Positive → TB treatment Initiated				
Labs:								
□ CBC q: □ CMP q: □ CRP q: □ ESR q: □ LFTs q: □ X-Ray: □ Other:								
AVSOLA® ORDERS								
	start	☐ Restart ☐ Continued therap	ov To	otal Doses Received:	Date of Last Infusion:			
Medication		Direction		Quantity/Refills				
Wicalcation		Direction	113		Loading dose: 3 doses. No refills.			
	Loading dose: 5mg/kg mg IV at w			eek: 0, 2, 6	Maintenance dose: 8-week supply. Refill x			
Avsola® (infliximab-axxq)	☐ 3mg	/kg mg	IV at w	eek: 0, 2, 6	1 year unless noted otherwise.			
	☐ Other:			week supply				
	☐ Mai	ntenance dose: (mg/kg) _		mg IV every weeks	Refill x 1 year unless noted otherwise.			
	<u> </u>			□ Other:				
Pre-Medication Dose/Strength				Directions				
☐ Acetaminophen ☐ 500mg ☐ T		☐ Tak	Take 1-2 tablets PO prior to infusion or post-infusion as directed					
□ Dinhanhudramia a		☐ 25mg IV/PO		\square Take 1 tablet PO prior to infusion or as directed OR				
☐ Diphenhydramine ☐ 50mg IV/PO			\square Inject contents of 1 vial IV prior to infusion or as directed					
☐ Methylprednisolone		☐ 40mg ☐ 125mg [☐ Inject contents of 1 vial IV prior to infusion or as directed				
INFUSION REACTION ORDERS								
Mild reaction protocol:								
☐ Diphenhydramine 25mg IV, one time, for pruritus.								

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If symptoms worsen, see orders for moderate to severe 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:						
☑ 0.9% Sodium Chloride 2-5mL IV flush before	re and 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-tunneled Catheter:					
 ☑ Heparin Sodium 10 units/mL 1mL IV ☑ Heparin Sodium 10 units/n IV final flush post normal saline flush 								
** May substitute Dextrose 5% in Water, or alternative, for 0.9& Sodium Chloride, when indicated due to incompatibility with medications bring infused								
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 oncurs navment by incurance carrier, please include cunnerting clinical documentation for encified ICD 10 Code, demographic, and incurance information along with faved order. Initial appointment								

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 appointmen will be verified upon insurance approval.

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