



PATIENT INFORMATION (Complete or Fax Existing 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: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)	
Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION	
ICD-10 Code(s) & Description: _____	
<b>PI: Attach Labs</b>	<b>CIDP: Attach reports</b>
IgA Level (mg/dL): _____ Pre-Titer Level (mcg/mL): _____	EMG/NCS/Nerve Ultrasound (m/sec): _____
IgG Level (mg/dL): _____ IgM Level (mg/Dl): _____	NF155 Levels: _____ CNTN1 Levels: _____
Post Titer Level mcg/mL: _____	MRI Results: _____

ORDERS	
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy	Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Indication
<input type="checkbox"/> HyQvia® [Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase] Solution.	<input type="checkbox"/> For PI: <input type="checkbox"/> If switching from IVIG (human) treatment, administer HYQVIA at the same dose and frequency as the previous IV treatment, after the initial dose ramp-up <input type="checkbox"/> If naive to SCIG (human) treatment or switching from SCIG, administer HYQVIA at 300 mg/kg to 600 mg/kg at 3-week or 4-week intervals, after the initial ramp-up <input type="checkbox"/> For CIDP: <input type="checkbox"/> If switching from IVIG (human) treatment, administer HYQVIA at the same dose and frequency as the previous IV treatment, after the initial dose ramp-up

Dose/Frequency	
<input type="checkbox"/> Infusion provider to calculate ramp-up dose per the ramp-up	
Patient weight (kg): _____ x dose (mg/kg): _____	Frequency: <input type="checkbox"/> every 2 weeks <input type="checkbox"/> every 3 weeks <input type="checkbox"/> every 4 weeks Refills: _____
Number of infusion site(s): <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 Infusion site(s): <input type="checkbox"/> Middle to upper abdomen <input type="checkbox"/> Thigh(s)	
High-flow 24G needle length (check one): <input type="checkbox"/> 6mm <input type="checkbox"/> 9mm <input type="checkbox"/> 12mm <input type="checkbox"/> 14mm	

Pre-Medication	Dose/Strength	Directions
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> 500mg	<input type="checkbox"/> Take 1-2 tablets PO prior to infusion or post-infusion as directed
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 25mg <input type="checkbox"/> 50mg	<input type="checkbox"/> Take 1 tablet PO prior to infusion or as directed OR
<input type="checkbox"/> _____	_____	_____

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**INFUSION REACTION ORDERS**

**Mild reaction protocol:**

Diphenhydramine 25mg IV, one time, for pruritus.

*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

Famotidine 20mg IV, one time, for, 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:**

0.9% Sodium Chloride 2-5mL IV flush before and after each infusion

**Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:**

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:**

Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush

**PICC:**

Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush

**Implanted Port, Tunneled Catheter, and Non-tunneled Catheter:**

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, when indicated due to incompatibility with medications being 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 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.

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