



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ DEA: _____
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: _____	RX Card (PBM): _____
City, State, Zip: _____	BIN: _____ PCN: _____
Plan #: _____	City, State, Zip: _____
Group #: _____	Group #: _____
Phone: _____	Phone: _____

CLINICAL INFORMATION
Diagnosis/ ICD 10 Code: <input type="checkbox"/> D50.9 Iron deficiency anemia <input type="checkbox"/> Other: _____
Lab work: Serum Ferritin level: _____ TIBC (iron % binding panel): _____ CBC: _____ Other: _____

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	Directions	Quantity/Refills
<input type="checkbox"/> Injectafer (ferric carboxy-Maltose) 750mg IV	Mix in 100ml NS and give over 30 minutes. Observe Patient for 30 minutes afterward. 2 doses should be at least 5-7 days apart.	Quantity: _____ Refills: _____

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 _____ Prescriber Signature	Date: _____

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.