TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

ACTEMRA®

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

Primary ICD-10 Code (Please Specify Diagnosis): _____
Secondary ICD-10 Code (Please Specify Diagnosis): _____
Date of negative TB test: _____ ☐ TB test pending, will fax results. Patient is HBV negative or has been treated: ☐ Yes ☐ No
History of kidney disease: ☐ Yes ☐ No *If yes*, SCr: _____ GFR/CrCl: _____ History of heart failure: ☐ Yes ☐ No

Required Labs:	ANC	Platelet	AST	ALT	SCr	Lipids
Results:	_____	_____	Result: _____ Upper limit of normal: _____	Result: _____ Upper limit of normal: _____	_____	_____

ACTEMRA® ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Strength	Dose/Frequency	Refills
☐ Actemra (Tocilizumab)	☐ 20mg/mL vial ☐ Other: _____	☐ 4mg/kg IV every 4 weeks with max dose of 800 mg for weight >100 kg ☐ 6mg/kg IV every 4 weeks with max dose of 600 mg for weight >100kg ☐ 8 mg/kg IV every 4 weeks with max dose of 800 mg for weight >100kg ☐ 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.