



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						
Primary ICD-10 Code (Please Specify Diagnosis): _____						
Secondary ICD-10 Code (Please Specify Diagnosis): _____						
Date of negative TB test: _____ <input type="checkbox"/> TB test pending, will fax results. Patient is HBV negative or has been treated: <input type="checkbox"/> Yes <input type="checkbox"/> No						
History of kidney disease: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, SCr: _____ GFR/CrCl: _____</i> History of heart failure: <input type="checkbox"/> Yes <input type="checkbox"/> No						
Required Labs:	ANC	Platelet	AST	ALT	SCr	Lipids
Results:	_____	_____	Result: _____ Upper limit of normal: _____	Result: _____ Upper limit of normal: _____	_____	_____

ACTEMRA® 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	Strength	Dose/Frequency	Refills
<input type="checkbox"/> Actemra (Tocilizumab)	<input type="checkbox"/> 20mg/mL vial <input type="checkbox"/> Other: _____	<input type="checkbox"/> 4mg/kg IV every 4 weeks with max dose of 800 mg for weight >100 kg <input type="checkbox"/> 6mg/kg IV every 4 weeks with max dose of 600 mg for weight >100kg <input type="checkbox"/> 8 mg/kg IV every 4 weeks with max dose of 800 mg for weight >100kg <input type="checkbox"/> 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.

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