



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			
<input type="checkbox"/> D80 Immunodeficiency with predominantly antibody defects	<input type="checkbox"/> D80.1 Nonfamilial hypogammaglobulinemia	<input type="checkbox"/> D80.3 Selective deficiency of immunoglobulin G [IgG] subclasses	<input type="checkbox"/> D83.9 Common variable immunodeficiency (unspecified)
<input type="checkbox"/> G61.0 Guillain-Barré Syndrome	<input type="checkbox"/> G61.81 CIDP	<input type="checkbox"/> G61.82 Multifocal motor neuropathy	<input type="checkbox"/> G70.00 Myasthenia gravis
<input type="checkbox"/> G70.01 Myasthenia Gravis with (acute) exacerbation	<input type="checkbox"/> M33.10 Other dermatomyositis, organ involvement unspecified	<input type="checkbox"/> M33.22 Polymyositis with myopathy	<input type="checkbox"/> M33.12 Dermatomyositis with myopathy
<input type="checkbox"/> Other ICD-10 Code (Please Specify Diagnosis): _____			
Vascular access: <input type="checkbox"/> Peripheral <input type="checkbox"/> Central <input type="checkbox"/> Port Infusion method: <input type="checkbox"/> Gravity <input type="checkbox"/> Pump			
Adverse Reactions with Previous IG treatments? <input type="checkbox"/> No <input type="checkbox"/> Yes Reason/Brand: _____			

TRIED AND/OR FAILED MEDICATIONS	LEGNTH OF THERAPY	REASON FOR DISCONTINUATION
_____ / _____ / _____	_____ / _____ / _____	_____ / _____ / _____
_____ / _____ / _____	_____ / _____ / _____	_____ / _____ / _____

IVIG 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		Dose/Frequency	Refills
<input type="checkbox"/> Asceniv™ 10%	<input type="checkbox"/> Bivigam® 10%	<input type="checkbox"/> Gammagard® liquid 10%	_____
<input type="checkbox"/> Gammagard® S/D 5%	<input type="checkbox"/> Gammagard® S/D 10%	<input type="checkbox"/> Gammaked™ 10%	
<input type="checkbox"/> Gamunex®-C 10%	<input type="checkbox"/> Octagam® 5%	<input type="checkbox"/> Octagam® 10%	
<input type="checkbox"/> Panzyga® 10%	<input type="checkbox"/> Privigen® 10%	<input type="checkbox"/> Non-Branded	
<input type="checkbox"/> Infuse _____ grams intravenously every _____ weeks. <input type="checkbox"/> Infuse _____ g/kg intravenously every _____ weeks. <input type="checkbox"/> Infuse _____ mg/kg intravenously every _____ weeks. <input type="checkbox"/> Other: _____			
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 IV/PO <input type="checkbox"/> 50mg IV/PO	<input type="checkbox"/> Take 1 tablet PO prior to infusion or as directed OR <input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed	
<input type="checkbox"/> Methylprednisolone	<input type="checkbox"/> 40mg <input type="checkbox"/> 125mg	<input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed	
<input type="checkbox"/> Sodium Chloride 0.9%	<input type="checkbox"/> 500 mL	<input type="checkbox"/> Infuse 500mL prior to each infusion or as directed	

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<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 mid-antrolateral 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: <input checked="" type="checkbox"/> 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion	Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter: <input checked="" type="checkbox"/> 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: <input checked="" type="checkbox"/> Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush	PICC: <input checked="" type="checkbox"/> Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush	Implanted Port, Tunneled Catheter, and Non-tunneled Catheter: <input checked="" type="checkbox"/> 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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