

PATIENT INFORMATION (Complete or fax existing chart)		PRESCRIBER INFORMATION	
Patient Name: _____		Prescriber Name: _____	
Address: _____		State License: _____ NPI #: _____	
City, State, Zip: _____		DEA: _____ Phone: _____	
Phone: _____ 2 nd Phone: _____		Address: _____ Fax: _____	
DOB: _____ Gender: M F Last 4 SSN: _____		City, State, Zip: _____	
Weight: _____ Ht: _____ Allergies: _____		Contact Person: _____ Phone: _____	
INSURANCE INFORMATION - INSTEAD - just send us 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: _____	
DIAGNOSIS /CLINICAL INFORMATION			
<input type="checkbox"/> J45.40 Moderate Persistent Asthma, Uncomplicated		<input type="checkbox"/> M30.1 Polyarteritis with lung involvement [Churg-Strauss]	
<input type="checkbox"/> J45.50 Severe persistent asthma, uncomplicated		<input type="checkbox"/> J33.9 Nasal Polyps, Unspecified <input type="checkbox"/> J33.0 Polyp of Nasal Cavity	
<input type="checkbox"/> J45.51 Severe persistent asthma with (acute) exacerbation		<input type="checkbox"/> L50.1 Idiopathic urticaria	
Eosinophil Count: _____ cells/μL Date of Test: _____		<input type="checkbox"/> Other: _____	
Needs by Date: _____		Ship to: Patient Office Other: _____	
Lab Orders: _____			
Fasenra			
<input type="checkbox"/> FASENRA® (benralizumab) 30 mg/mL single-dose prefilled syringe (administered by healthcare professional)		<input type="checkbox"/> Loading Dose 30 mg/mL solution in a single dose administered by subcutaneous injection once every 4 weeks for 3 doses QTY: _____ Refills: _____	
<input type="checkbox"/> FASENRA Pen™ (benralizumab) 30 mg/mL single-dose autoinjector (Self-administered)		<input type="checkbox"/> Maintenance Dose 30 mg/mL solution in a single dose administered by subcutaneous injection once every 8 weeks – QTY: _____ Refills: _____	
Nucala			
<input type="checkbox"/> Prefilled syringe <input type="checkbox"/> Vial <input type="checkbox"/> Pen			
<input type="checkbox"/> Inject 100 mg subcutaneously once every 4 weeks			
<input type="checkbox"/> Inject 300 mg (3 separate 100 mg injections) subcutaneously once every 4 weeks			
<input type="checkbox"/> Inject _____ mg (____ separate 100 mg injections) subcutaneously once every ____ weeks			
Dupixent Pre-filled syringe, package of 2			
<input type="checkbox"/> Initial dose: 400 mg SIG: 2 (200 mg/1.14 mL) injections SQ on Day 1		<input type="checkbox"/> Initial dose: 600 mg SIG: 2 (300 mg/2 mL) injections SQ on Day 1	
Subsequent (maintenance) dose: 200 mg		Subsequent (maintenance) dose: 300 mg	
SIG: 1 (200 mg/1.14 mL) injection SQ every 2 weeks, starting on Day 15		SIG: 1 (300 mg/2 mL) injection SQ every 2 weeks, starting on Day 15	
Other: Initial: _____			
Subsequent: Dose _____ Frequency _____			
QTY: _____ pk (2 syringes) Refills _____			
Xolair			
<input type="checkbox"/> Prefilled syringe <input type="checkbox"/> Vial		Prescription Type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued Tx	
Last injection date: _____			
SIG <input type="checkbox"/> 75 mg/dose every 4 weeks		SIG <input type="checkbox"/> 150 mg/dose every 4 weeks	
SIG <input type="checkbox"/> 300 mg/dose every 4 weeks		SIG <input type="checkbox"/> 225 mg/dose every 2 weeks	
SIG <input type="checkbox"/> 375 mg/dose every 2 weeks		SIG <input type="checkbox"/> 300 mg/dose every 2 weeks	
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: _____	
Physician's Signature			

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.