



| 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"/> L40.0 Psoriasis vulgaris (Plaque psoriasis) <input type="checkbox"/> L40.50 Arthropathic psoriasis, unspecified <input type="checkbox"/> K51.00 Ulcerative (chronic) pancolitis without complications <input type="checkbox"/> Other ICD-10 Code(s): _____ Date of diagnosis or years with disease: _____ Previous TB Test (date) : _____ |

| 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"/> DERMATOLOGY/RHEUMATOLOGY | Starter Dose: <input type="checkbox"/> Single-dose One-Press patient-controlled injector; 100 mg/mL SQ at <input type="checkbox"/> Week 0 <input type="checkbox"/> Week 4 <input type="checkbox"/> Single-dose prefilled syringe; 100 mg/mL SQ at <input type="checkbox"/> Week 0 <input type="checkbox"/> Week 4 Maintenance Therapy: <input type="checkbox"/> Single-dose One-Press patient-controlled injector; 100 mg/mL SQ every 8 weeks <input type="checkbox"/> Single-dose prefilled syringe; 100 mg/mL SQ every 8 weeks | _____ |
| <input type="checkbox"/> GASTROENTEROLOGY | Starter Dose: <input type="checkbox"/> 200 mg IV infusion at week 0, week 4, and week 8 Maintenance Therapy: <input type="checkbox"/> Single-dose One-Press patient-controlled injector; 100 mg/mL SQ at week 16 and every 8 weeks <input type="checkbox"/> Single-dose prefilled syringe; 100 mg/mL SQ at week 16 and every 8 weeks <input type="checkbox"/> Single-dose prefilled pen; 200 mg/2 mL SQ at week 12 and every 4 weeks <input type="checkbox"/> Single-dose prefilled syringe; 200 mg/2 mL SQ at week 12 and every 4 weeks | _____ |

| 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"/> _____ | _____ | _____ |

| INFUSION REACTION ORDERS |
|--------------------------------|
| Mild reaction protocol: |

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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 mis-anterolateral 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 bring 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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