



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"/> G35 Multiple Sclerosis	<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"/> M33.2 Polymyositis	<input type="checkbox"/> M33.90 Dermatomyositis
<input type="checkbox"/> M33.10 Other dermatomyositis, organ involvement unspecified		<input type="checkbox"/> Other: _____	
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		
<input type="checkbox"/> Asceniv™ 10%	<input type="checkbox"/> Bivigam® 10%	<input type="checkbox"/> Gammagard® liquid 10%	<input type="checkbox"/> Infuse _____ grams intravenously every _____ weeks.		
<input type="checkbox"/> Gammagard® S/D 5%	<input type="checkbox"/> Gammagard® S/D 10%	<input type="checkbox"/> Gammaked™ 10%	<input type="checkbox"/> Infuse _____ g/kg intravenously every _____ weeks.		
<input type="checkbox"/> Gamunex®-C 10%	<input type="checkbox"/> Octagam® 5%	<input type="checkbox"/> Octagam® 10%	<input type="checkbox"/> Infuse _____ mg/kg intravenously every _____ weeks.		
<input type="checkbox"/> Panzyga® 10%	<input type="checkbox"/> Privilgen® 10%	<input type="checkbox"/> Non-Branded	<input type="checkbox"/> Other: _____		
Pre-Medication	Route	Dose	Directions	Quantity	Refills
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> PO <input type="checkbox"/> IV (ofirmev)	<input type="checkbox"/> 325mg <input type="checkbox"/> 500mg <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pre-Med: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> With Each Infusion <input type="checkbox"/> Other: _____	#: _____
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> PO <input type="checkbox"/> IV	<input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pre-Med: _____ <input type="checkbox"/> PRN Reaction: _____	<input type="checkbox"/> With Each Infusion <input type="checkbox"/> Other: _____	#: _____
<input type="checkbox"/> Other: _____	_____	_____	_____	_____	#: _____
IV Fluids		Route	Dose	Directions	Quantity
<input type="checkbox"/> Normal Saline 0.9%		<input type="checkbox"/> IV	_____	<input type="checkbox"/> Before and after infusion <input type="checkbox"/> Other: _____	<input type="checkbox"/> With Each Infusion <input type="checkbox"/> Other: _____
<input type="checkbox"/> ½ Normal Saline 0.45%					
<input type="checkbox"/> Dextrose 5%					

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Please Send a Copy of The Patient's Insurance Cards (Front & Back)

<input type="checkbox"/> Other: _____	_____	_____	_____	_____	#: _____
Flush	Route	Dose	Directions	Quantity	Refills
<input type="checkbox"/> Normal Saline 0.9%	<input type="checkbox"/> IV	<input type="checkbox"/> 3 mL <input type="checkbox"/> 5mL <input type="checkbox"/> 10mL	<input type="checkbox"/> Before and after infusion <input type="checkbox"/> Other: _____	<input type="checkbox"/> With Each Infusion <input type="checkbox"/> Other: _____	#: _____
<input type="checkbox"/> Heparin 10 units/ml <input type="checkbox"/> Heparin 100 units/ml	<input type="checkbox"/> IV	<input type="checkbox"/> 3 mL <input type="checkbox"/> 5mL <input type="checkbox"/> 10mL	<input type="checkbox"/> After infusion <input type="checkbox"/> Other: _____	<input type="checkbox"/> With Each Infusion <input type="checkbox"/> Other: _____	#: _____
Anaphylaxis	Route	Dose	Directions	Quantity	Refills
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> IV <input type="checkbox"/> PO <input type="checkbox"/> IM	<input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pre-Med: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> With Each Infusion <input type="checkbox"/> Other: _____	#: _____
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> IM <input type="checkbox"/> SQ	<input type="checkbox"/> Adult: 0.3mL (0.3mg) <input type="checkbox"/> Peds: 0.15mL (0.15mg)	<input type="checkbox"/> PRN Anaphylaxis <input type="checkbox"/> Repeating Dose: _____	<input type="checkbox"/> Once <input type="checkbox"/> Other: _____	#: _____
<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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