



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ DEA: _____
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 (Please Specify Diagnosis): _____	Secondary ICD-10 (Please Specify Diagnosis): _____
Tertiary ICD-10 (Please Specify Diagnosis): _____	
Is the patient on iron, folate and/or vitamin B12 therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient on dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has patient received any ESA therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many weeks of ESA therapy has the patient completed? _____ weeks	
Patient's hemoglobin (Hgb) level: _____ g/dL	

ARANESP® 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"/> Aranesp® (darbepoetin alfa) Single Dose Vials <input type="checkbox"/> Aranesp® (darbepoetin alfa) Single Dose Prefilled Syringe	<input type="checkbox"/> 25 mcg <input type="checkbox"/> 40 mcg <input type="checkbox"/> 60 mcg <input type="checkbox"/> 100 mcg <input type="checkbox"/> 150 mcg <input type="checkbox"/> 200 mcg <input type="checkbox"/> 300 mcg <input type="checkbox"/> Other: _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Other: _____	Refills: _____

Special Instructions: _____		
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"/> _____	_____	_____

INFUSION REACTION ORDERS	
Mild reaction protocol:	
<input checked="" type="checkbox"/> Diphenhydramine 25mg IV, one time, for pruritus.	
<i>If symptoms worsen, see orders for moderate to severe reactions.</i>	
Moderate reaction protocol:	

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