



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: _____	RX Card (PBM): _____
City, State, Zip: _____	BIN: _____ PCN: _____
Plan #: _____	City, State, Zip: _____
Group #: _____	Group #: _____
Phone: _____	Phone: _____

Secondary Insurance (If Applicable):

Secondary Insurance: _____	City, State, Zip: _____
Plan #: _____	Group #: _____
Phone: _____	

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? Yes No Is the patient on dialysis? Yes No

Has patient received any ESA therapy? Yes No If yes, how many weeks of ESA therapy has the patient completed? _____ weeks

Patient's hemoglobin (Hgb) level: _____ g/dL

ORDERS

Prescription type: New start Restart Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose/Frequency	Refills
<input type="checkbox"/> Procrit®(epoetin alfa) <input type="checkbox"/> Retacrit™ (epoetin-alfa-ebpx)	<input type="checkbox"/> _____ mg/kg <input type="checkbox"/> _____ units Dosing Directions (include frequency): _____ _____	Refills: _____

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.

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.