



## Please Fax Completed Form To: 888-898-9113

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

Please Send a Copy of The Patient's Up-to-Date Clinical Notes

PATIENT INFORMATION (Complete or Fax Existing Chart)			PRESCRIBER INFORMATION			
Name: DOB: Address: City, State, Zip: Phone: Alt. Phone: Email: SS#: Gender: _ M _ F Weight: (lbs) Ht: Allergies: INSURANCE INFORMATION – AND – Send a copy of the patient			Prescriber Name:  State License:  NPI #:  Tax ID:  Address:  City, State, Zip:  Phone:  Office Contact:  Phone:  Phone:  Phone:  Phone:  Phone:  Phone:  Phone:  Phone:  Phone:  Phone:			
Primary Insurance:			Secondary Insurance (If Applicable):  Plan #:  Group #:  RX Card (PBM):  BIN: PCN:			
CLINICAL INFORMATION  Primary ICD-10 Code (Please Spreading ICD-10 Code (Please Date of negative TB test:  History of kidney disease:  History of kidney disease:  ANC:  AST:  UI  ACTEMRA® ORDERS  Prescription type:  New start  Medication	Specify Diagnosis): TB test perpending TB to the strong TB to the s	nding, will fax res GFR/CrCl: atelet: I therapy Total 4mg/kg IV ev 6mg/kg IV ev 8 mg/kg IV ev	Doses Receivery 4 weeksvery 4 weeksvery 4 weeks	ent is HBV negat History of hear SCr: ved:  Dose/Frequer with max dose of	ive or has been treated:  Yes t failure:  Yes Lipids:  Upper limit of normal:  Date of Last Injection/Infusioncy of 800 mg for weight >100 kg of 600 mg for weight >100kg of 800 mg for weight >100kg	
INFUSION REACTION ORD  Mild reaction protocol:  ☑ Diphenhydramine 25mg IV, of symptoms worsen, see orders  Moderate reaction protocol:  ☑ Acetaminophen 650mg PO, of incomposition in the symptoms worsen, see interversely in the symptoms worsen, see interversely in the symptoms worsen, see interversely interversely in the symptoms worsen, see interversely interversely in the symptoms worsen, see interversely interverse	one time, for pruritus.  for moderate to severe reactions or rigor one time, for pyrexia or rigor one time, for pruritus or urt V, one time, for respiratory entions for severe reactions 911 if initiated):  s flow per nasal cannula or	ctions. rs icaria r or neurologic sy face mask to mai	mptoms ntain spO2 c	of greater than ni		

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☑ Methylprednisolone 125mg IV, one time, for res	spiratory symptoms, eden	na, or anaphylaxis						
⊠ Sodium Chloride 0.9% 500mL IV over 30-60 min	, one time, for cardiovasc	ular symptoms						
☑ Epinephrine 0.3mg/0.3mL IM into mis-anterolat worsen	eral aspect of thigh of and	aphylaxis, may repeat x1 i	in 5-15 minutes if symptoms are not resolved or					
FLUSHING & LOCKING ORDERS								
Flushing Protocol (>66lbs/33kg)								
PIV and Midline:		Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:						
oximes 0.9% Sodium Chloride 2-5mL IV flush before and	d after each infusion	☑ 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-					
☐ Heparin Sodium 10 units/mL 1mL IV final	☐ Heparin Sodium 10 units/mL 3mL IV final		tunneled Catheter:					
flush post normal saline flush	flush post normal saline flush		□ Heparin Sodium 100 units/mL 3-5mL IV final					
			flush post normal saline flush					
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:						

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.

**Prescriber Signature** 

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