TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

ARANESP®

Please Fax Completed Form To: 888-898-9113

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

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____
NPI #: _____ DEA: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Office Contact: _____ Phone: _____

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)

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

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

Secondary Insurance (If Applicable):

Secondary Insurance: _____
Plan #: _____
Phone: _____

City, State, Zip: _____
Group #: _____

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

ARANESP® ORDERS

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

Medication	Dose/Frequency	Refills
☐ Aranesp® (darbepoetin alfa) Single Dose Vials ☐ Aranesp® (darbepoetin alfa) Single Dose Prefilled Syringe	☐ 25 mcg ☐ 40 mcg ☐ 60 mcg ☐ 100 mcg ☐ 150 mcg ☐ 200 mcg ☐ 300 mcg ☐ Other: _____ ☐ Weekly ☐ Every 2 Weeks ☐ Other: _____	Refills: _____

Special Instructions: _____

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.