



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION	
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____	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: _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____	Secondary Insurance (If Applicable): _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____	
CLINICAL INFORMATION		
<input type="checkbox"/> J82.83 Severe Eosinophilic Asthma <input type="checkbox"/> L50.1 Chronic Idiopathic Urticaria <input type="checkbox"/> Other: _____  Prior Anaphylactic Reaction: <input type="checkbox"/> No <input type="checkbox"/> Yes (Reason/Date): _____  <b>Lab Results:</b> Positive Skin or RAST test to Perennial Aeroallergen: <input type="checkbox"/> Yes <input type="checkbox"/> No      Test Date: _____ - _____ - _____ Serum IgE Level _____ IU/ML      Test Date: _____ - _____ - _____ Serum Eosinophil Level: _____ cells/mcL      Test Date: _____ - _____ - _____ Sputum Eosinophiles _____ cells/mcL      Test Date: _____ - _____ - _____		
XOLAIR® ORDERS		
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy              Total Doses Received: _____              Date of Last Injection: _____		
Medication	Directions	Quantity/Refills
<input type="checkbox"/> Xolair® (omalizumab) 75mg <input type="checkbox"/> Xolair® (omalizumab) 150mg	<input type="checkbox"/> Inject _____ mg SQ every 2 weeks <input type="checkbox"/> Inject _____ mg SQ every 4 weeks	<input type="checkbox"/> 1-month supply <input type="checkbox"/> Other: _____ Refills: _____
<input type="checkbox"/> Epinephrine 0.3mg auto injector (2-pack) <input type="checkbox"/> EpiPen®	<input type="checkbox"/> 0.3mg IM as needed for anaphylaxis <input type="checkbox"/> 0.15mg IM as needed for anaphylaxis	<input type="checkbox"/> 1-month supply Refill x 1 year unless noted otherwise 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 _____ Prescriber Signature		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.

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