TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

XOLAIR®

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: _____
Plan #: _____
Group #: _____
RX Card (PBM): _____
BIN: _____ PCN: _____

Secondary Insurance (If Applicable): _____
Plan #: _____
Group #: _____
RX Card (PBM): _____
BIN: _____ PCN: _____

CLINICAL INFORMATION

☐ J82.83 Severe Eosinophilic Asthma ☐ L50.1 Chronic Idiopathic Urticaria ☐ Other: _____

Prior Anaphylactic Reaction: ☐ No ☐ Yes (Reason/Date):_____

Lab Results:

Positive Skin or RAST test to Perennial Aeroallergen: ☐ Yes ☐ 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: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection: _____

Medication	Directions	Quantity/Refills
☐ Xolair® (omalizumab) 75mg ☐ Xolair® (omalizumab) 150mg	☐ Inject _____mg SQ every 2 weeks ☐ Inject _____mg SQ every 4 weeks	☐ 1-month supply ☐ Other: _____ Refills: _____
☐ Epinephrine 0.3mg auto injector (2-pack) ☐ EpiPen®	☐ 0.3mg IM as needed for anaphylaxis ☐ 0.15mg IM as needed for anaphylaxis	☐ 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_____ 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.