TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

# IVIG

**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 #: _____ Tax ID: _____
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

☐ D80 Immunodeficiency with predominantly antibody defects
☐ D80.1 Nonfamilial hypogammaglobulinemia
☐ D80.3 Selective deficiency of immunoglobulin G [IgG] subclasses
☐ D83.9 Common variable immunodeficiency (unspecified)
☐ G35 Multiple Sclerosis
☐ G61.0 Guillain-Barré Syndrome
☐ G61.81 CIDP
☐ G70.00 Myasthenia gravis
☐ G70.01 Myasthenia Gravis with (acute) exacerbation
☐ M33.2 Polymyositis
☐ M33.90 Dermatomyositis
☐ M33.10 Other dermatomyositis, organ involvement unspecified
☐ Other: _____

Vascular access: ☐ Peripheral ☐ Central ☐ Port Infusion method: ☐ Gravity ☐ Pump

Adverse Reactions with Previous IG treatments? ☐ No ☐ Yes Reason/Brand: _____

| TRIED AND/OR FAILED MEDICATIONS | LEGNTH OF THERAPY | REASON FOR DISCONTINUATION |
|---|---|---|
| | | |
| | | |

## IVIG ORDERS

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

| Medication | | | Dose/Frequency |
|---|---|---|---|
| ☐ Asceniv™ 10% | ☐ Bivigam® 10% | ☐ Gammagard® liquid 10% | ☐ Infuse _____ grams intravenously every _____ weeks. |
| ☐ Gammagard® S/D 5% | ☐ Gammagard® S/D 10% | ☐ Gammaked™ 10% | ☐ Infuse _____ g/kg intravenously every _____ weeks. |
| ☐ Gamunex®-C 10% | ☐ Octagam® 5% | ☐ Octagam® 10% | ☐ Infuse _____ mg/kg intravenously every _____ weeks. |
| ☐ Panzyga® 10% | ☐ Privigen® 10% | ☐ Non-Branded | ☐ Other: _____ |

| Pre-Medication | Route | Dose | Directions | Quantity | Refills |
|---|---|---|---|---|---|
| ☐ Acetaminophen | ☐ PO<br>☐ IV (ofirmev) | ☐ 325mg ☐ 500mg<br>☐ Other: _____ | ☐ Pre-Med: _____<br>☐ Other: _____ | ☐ With Each Infusion<br>☐ Other: _____ | #: _____ |
| ☐ Diphenhydramine | ☐ PO<br>☐ IV | ☐ 25mg ☐ 50mg<br>☐ Other: _____ | ☐ Pre-Med: _____<br>☐ PRN Reaction: _____ | ☐ With Each Infusion<br>☐ Other: _____ | #: _____ |
| ☐ Other: _____ | _____ | _____ | _____ | _____ | #: _____ |
| **IV Fluids** | **Route** | **Dose** | **Directions** | **Quantity** | **Refills** |
| ☐ Normal Saline 0.9%<br>☐ ½ Normal Saline 0.45%<br>☐ Dextrose 5% | ☐ IV | _____ | ☐ Before and after infusion<br>☐ Other: _____ | ☐ With Each Infusion<br>☐ Other: _____ | #: _____ |

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|---|---|---|---|---|---|
| ☐ Other: _____ | _____ | _____ | _____ | _____ | #: _____ |
| **Flush** | **Route** | **Dose** | **Directions** | **Quantity** | **Refills** |
| ☐ Normal Saline 0.9% | ☐ IV | ☐ 3 mL ☐ 5mL ☐ 10mL | ☐ Before and after infusion ☐ Other: _____ | ☐ With Each Infusion ☐ Other: _____ | #: _____ |
| ☐ Heparin 10 units/ml ☐ Heparin 100 units/ml | ☐ IV | ☐ 3 mL ☐ 5mL ☐ 10mL | ☐ After infusion ☐ Other: _____ | ☐ With Each Infusion ☐ Other: _____ | #: _____ |
| **Anaphylaxis** | **Route** | **Dose** | **Directions** | **Quantity** | **Refills** |
| ☐ Diphenhydramine | ☐ IV ☐ PO ☐ IM | ☐ 25mg ☐ 50mg ☐ Other: _____ | ☐ Pre-Med: _____ ☐ Other: _____ | ☐ With Each Infusion ☐ Other: _____ | #: _____ |
| ☐ Epinephrine | ☐ IM ☐ SQ | ☐ Adult: 0.3mL (0.3mg) ☐ Peds: 0.15mL (0.15mg) | ☐ PRN Anaphylaxis ☐ Repeating Dose: _____ | ☐ Once ☐ Other: _____ | #: _____ |
| ☐ 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: s_____

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.