



Tezspire

Provider Order Form

PATIENT INFORMATION

Patient Name:		DOB:
Patient Home Phone:	Patient Cell Phone:	Patient Email:
Emergency/Alternate Contact Name:		Emergency/Alternate Contact Phone:
<input type="radio"/> NKDA	<input type="radio"/> Allergies:	Weight lbs/kg: Height:
Patient Status: <input type="radio"/> New to Therapy <input type="radio"/> Continuing Therapy <input type="radio"/> Therapy Change		Last infusion date (if applicable):

REQUIRED DOCUMENTATION

Labs (Touch Authorization) Insurance Card (front and back) Current Medications History/Progress Notes

ICD-10 CODE

J45.50 Severe persistent asthma, uncomplicated J45.51 Severe persistent asthma with acute exacerbation

Other: _____

PRE-MEDICATION ORDER

Acetaminophen (Tylenol) <input type="radio"/> 500mg <input type="radio"/> 650mg <input type="radio"/> 1000mg PO	Diphenhydramine (Benadryl) <input type="radio"/> 25mg <input type="radio"/> 50mg <input type="radio"/> PO <input type="radio"/> IV
Cetirizine (Zyrtec) <input type="radio"/> 10mg PO	Methylprednisolone (Solu-Medrol) <input type="radio"/> 40mg IV <input type="radio"/> 125mg IV
Loratadine (Claritin) <input type="radio"/> 10mg PO	Hydrocortisone (Solu-Cortef) <input type="radio"/> 100mg IV
Other: _____ Dose: _____ Route: _____ Frequency: _____	

MEDICATION ORDER

Tezspire (tezepelumab-ekko) **Dose:** 210mg SC **Frequency:** every 4 weeks

PROVIDER INFORMATION

Provider Name:	Provider Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip:

SPECIAL INSTRUCTIONS

Provider Name **Provider Signature** **Date** Check here if this is a stat order

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.