Tezspire Order Form
(tezepelumab-ekko)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

☐ J45.50 Severe Persistent Asthma, Uncomplicated

☐ J45.51 Severe Persistent Asthma, w/ Acute Exacerbation

Other: _____

Prescribing information

If patient currently or recently on another therapy for this condition, please specify desired washout period.

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

LAB RESULTS: **Lab results and/or Pulmonary Function Tests to support diagnosis.**

PRESCRIPTION

TEZSPIRE (Tezepelumab-ekko)

Loading Dose

SubQ: Inject 210 mg every 4 weeks

Duration: _____

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**
If yes, please note therapy and last dose: _____

Post Treatment Observations: The patient is observed for 30 minutes following the first injection.

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Comments:

_____

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____