

TEZSPIRE

Provider Order Form rev. 1/01/2022



PATIENT INFORMATION

Patient Name: _____ DOB: _____

NKDA Allergies: _____ Weight lbs/kg: _____

Patient Status: New to Therapy Continuing Therapy Next Due Date (if applicable): _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

ICD-10 Code

- J45.50 Severe persistent asthma, uncomplicated
- J45.51 Severe persistent asthma with (acute) exacerbation
- Other _____

MEDICATION ORDER

- Tezspire**
 - Dose: 210 mg administered subcutaneously once every 4 weeks

Refills: Zero / 12 mos /
 Other _____

(all referrals will be honored for one year from date signed unless otherwise indicated)

SPECIAL INSTRUCTIONS

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

Provider Name (Print) _____ Provider Signature _____ Date _____

REQUIRED DOCUMENTATION

- Recent Office notes (along with any therapies tried and outcomes)
- Lab Results
- Insurance Cards (front and back)
- Current Medication
- Demographic Sheet
- History and Physical Report

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

- IgE
- Eosinophil count