

TN  
100 Covey Drive  
Suite 307  
Franklin, TN 37067



# ORDER FORM TEZESPIRE®

Date: \_\_\_\_\_

## PATIENT INFORMATION

Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
Allergies:	Date of Referral:	

## PHYSICIAN INFORMATION

Physician Name*:	Practice Name:
Address:	Office Contact*:
Phone: _____ Fax: _____	Email (for updates):

## REFERRAL STATUS

New Referral     Referral Renewal     Medication/Order Change     Benefits Verification Only     Discontinuation Order

**TEZESPIRE\*:**

\_\_\_\_\_ Dosing: 210mg subcutaneous every 4 weeks  
\_\_\_\_\_ Other

### Total Doses:

Yea \_\_\_\_\_  
Other \_\_\_\_\_  
Refill \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date (Order is Valid for One Year) \_\_\_\_\_

\*NPI # \_\_\_\_\_

*Infusion will be administered per MPP policy and protocols*

### ICD 10 Description:

### REQUIRED DOCUMENTATION CHECKLIST:

\_\_\_\_\_ Patient Demographics  
\_\_\_\_\_ Insurance Card/Information  
\_\_\_\_\_ Clinical/Progress Notes supporting DX  
\_\_\_\_\_ Current Medication List and H&P  
\_\_\_\_\_ Other

Last Infusion/Injection Date: \_\_\_\_\_

NOTES/ADDITIONAL COMMENTS:

## ORDERING PROVIDER

Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_