Los Angeles, CA
2080 Century Park East
Suite 710
Los Angeles, CA 90067

ThrIVewell INFUSION WEST

Office: 310-481-9944 Fax : 310-766-7001

MMI

(Tezepelumab)

TEZSPIRE

Infusion orders

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

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

PHYSICIAN INFORMATION

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

DIAGNOSIS *(and ICD 10 code)*

- ☐ Severe persistent asthma, uncomplicated — ICD 10 Code: J45.50
- ☐ Severe persistent asthma w/acute exacerbation — ICD 10 Code: J45.51
- ☐ Other: _____ — ICD 10 Code: _____

NOTE

List Tried & Failed Therapies, including duration of treatment:

1)
2)

TEZSPIRE (Tezepelumab) ORDERS

Medication ordered

210mg subcutaneous every 4 weeks

☐ Refills: ☐ X6 months / ☐ X1 year / ☐ _____ doses

Total dosages _____

PATIENT WEIGHT

_____ lbs.
_____ kg

REQUIRED DOCUMENTATION:

- ☐ This signed order form by the provider
- ☐ Patient demographics AND insurance information
- ☐ Clinical/Progress notes supporting primary diagnosis
- ☐ Labs and Tests supporting primary diagnosis

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____