

(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 _____