

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



(Tezepelumab)

TEZSPIRE

Infusion orders

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> 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 _____