Local Infusion

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TEZSPIRE (TEZEPELUMAB-EKKO) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

❑ Add-on maintenance treatment of adult and pediatric patients aged 12 years and older with severe asthma, ICD 10: J45._____

❑ Add-on maintenance treatment of adult and pediatric patients aged 12 years and older with inadequately controlled chronic rhinosinusitis with nasal polyps (CRSwNP), ICD 10: J32.9 (Chronic sinusitis, unspecified) and J33.9 (Nasal polyp, unspecified)

❑ Other:_____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO

❑ Famotidine 20 mg IV

❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Benadryl 25mg PO

❑ Cetirizine (Zyrtec) 10 mg PO

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Tezspire	210 mg	Subcutaneous Inj	Every 4 weeks

LABS / SPECIAL INSTRUCTIONS