Tezepelumab-ekko (Tezspire)

Provider Order Form *rev. 10/12/2022*

Fax Form to: 330-294-2082

INDY INFUSION

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Provide nursing care per Nursing Procedures, including reaction management and post procedure observation

THERAPY ADMINISTRATION

☑ **Tezepelumab-ekko** (Tezspire)
- Dose: 210 mg/1.91 mL (110 mg/mL) solution
- Route: subcutaneous injection
- Frequency: once every four weeks

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

Please include the following information when submitting a referral for Tezspire:

*** Clinicals that support severe asthma**

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