

TEZSPIRE (TEZPELUMAB-EKKO) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____
 Mobile Number: _____ Patient Weight: _____ kg
 Allergies: _____
 Patient has known difficult venous access. Comments: _____

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

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

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

FAX NUMBERS:

- CT: 203.433.0621
- MA: 413.296.8482
- NC: 919.984.8698
- NY: 631.250.6020
- SC: 864.973.6279
- FL: 904.877.9270
- MD: 240.224.8607
- NH: 603.217.5371
- OH: 937.871.4594
- VA: 703.202.0499
- ME: 207.407.7272
- NJ: 201.581.4521
- PA: 610.273.5998