Local Infusion

MYLOCALINFUSION.COM

TEZSPIRE (TEZEPELUMAB-EKKO) ORDER FORM

PATIENT INFORMATION

Patient Name: ______________________________ DOB: ____________

Mobile Number: ____________________ Patient Weight: ____________________

Allergies: ____

DIAGNOSIS (Provider must specify)

❑ Asthma, ICD 10: J45.______________________________________

❑ 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

❑ Benadryl 25mg PO

❑ Famotidine 20 mg IV

❑ Cetirizine (Zyrtec) 10 mg PO

❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ 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

FAX NUMBERS: ❒ CT: 203.433.0621 ❒ MD: 240.224.8607 ❒ ME: 207.407.7272 ❒ NH: 603.217.5371 ❒ NJ: 201.581.4521 ❒ VA: 703.202.0499

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