LIFE SPECIALTY SOLUTIONS

TEZSPIRE
(tezepelumab-ekko)

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

DATE OF BIRTH: _____ EMAIL: _____

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Medication List 5. Most Recent Labs
6. Tried/Failed Therapies

PRIMARY DIAGNOSIS

☐ J45.50 Severe persistent asthma, uncomplicated ☐ J45.51 Severe persistent asthma with (acute) exacerbation

☐ Other _____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Tezspire

☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ Tezspire 210 mg SubQ injection every 4 weeks. ☐ Other _____

FIRST DOSE?: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted.

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)

☐ Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____

OFFICE CONTACT: _____ FAX: _____

ADDRESS: _____ EMAIL: _____

CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

✖ _____ _____

PROVIDER SIGNATURE DATE