

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 Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.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: _____

X _____
 PROVIDER SIGNATURE DATE