PRESCRIPTION ORDER FORM

TEZSPIRE

(tezepelumab-ekko)

215 Pleasant Street, 5th Floor, Fall River, MA 02721
Phone: (508) 567-5666 | Fax: (508) 567-5614

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:________________lbs or ____________kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List •Tried/Failed Therapies

PRIMARY DIAGNOSIS

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

LAB ORDERS: PLEASE INCLUDE FREQUENCY

☐ CBC w/ diff & ANC: ______________________ ☐ LFT's at month 2 then every 3 months after ☐ Other: ______________________

PRE-MEDICATIONS (15 - 20 MINS BEFORE INFUSION)

☐ Diphenhydramine 25mg PO or IVP & 50mg PO or IVP ☐ Cetrizine 10mg PO ☐ Pepcid 20mg PO or IVP
☐Solu-Medrol 40mg IVP ☐Solu-Cortef 125mg IVP ☐ Tylenol 650mg PO ☐ Other: ______________________

PRIMARY MEDICATION ORDER

☐ Tezspire 210 mg SubQ injection every 4 weeks.
☐ Other: ____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:______________________

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Suite Life Health's protocol
(See suitelifehealth.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

Provider Signature

____
Date