Phone: (847) 324-6800 Fax: (224) 251-7141 Email: intake@infusacare.com

InfusaCare
MedFuse

Tezspire (Tezepelumab-ekko) Injection Order

Patient Name: DOB: □ Male □ Female

Diagnosis (please provide ICD10 code):

□ Other:

□ NKDA □ Allergies:

□ New Therapy Order □ Continuation of Therapy Date of last dose:

Ordering Provider Name:

Provider NPI: Phone: Fax:

Practice Address: City: State: Zip Code:

Pre-Medication

□ Acetaminophen _____mg by □ PO
□ Ceterizine _____mg by □ PO
□ Diphenhydramine _____mg by □ PO/ □ IVP
□ Solu-Medrol _____mg by □ PO/ □ IVP
□ Solu-Cortef _____mg by □ PO/ □ IVP
□ Other:

Required Documentation:

□ Patient Demographics
□ Patient Insurance (med and pharm card copies, front and back)
□ Progress Notes/Labs supporting diagnosis
□ History of tried and failed therapies, including duration
□ CBC/CMP
□ Absolute Eosinophil Count
□ Other:

Patient height and weight:

Patient Height (cm): Patient Weight (kg):

Tezspire Medication Order:

- Dosing (Please choose one):
  - □ 210 mg
  - □ Other: _____
- Frequency (Please choose one):
  - □ Every 4 weeks
  - □ Other: _____
- Duration (Please choose one):
  - □ For _____ doses
  - □ For 12 months
  - □ Other: _____

Additional Instructions/Notes:

Ordering Provider:

Signature: _____ Date: _____

Provider: _____ Phone: _____ Fax: _____

Best Contact Person in Office: _____ Phone: _____

Updated: 4/1/2024