MRN:_____

DOB: _____

Standard Plan of Treatment for Tezspire™ (tezepelumab-ekko)

NOTE: Patient ***may be ineligible*** to receive **TEZSPIRE™ (Tezepelumab-ekko)** if patient has signs/symptoms of a parasitic infection, is currently being treated for a parasitic infection, or is having an acute bronchospasm and/or asthma attack.

1. **Patient Name**: _____Height (in.):_____ Weight (lbs):_____
2. **Allergies**: _____
3. **Diagnosis:**

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

☐ Other **ICD-10 Code:**_____**Diagnosis description:**_____

4. Dose/Frequency:

Tezspire™ (Tezepelumab-ekko) 210mg every four (4) weeks via subcutaneous injection.

(Administer subcutaneously to upper arm, thigh, or abdomen)

Special Orders: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

5. Physician's Signature:_____/_____ **Date**: _____
(Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials:_____ NPI: _____

6. ***Fax updated supporting clinical MD notes with each order renewal or change in orders***

MRN:_____
DOB: _____

Guidelines for Prescribing

(Required documentation with all initial referrals)

Patient Name: _____ Referral Date: _____

☐ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-6)*

☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)

☐ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy. Include any lab results and/or Pulmonary Function Tests to support diagnosis**.

- TEZSPIRE is a thymic stromal lymphopoietin (TSLP) blocker, human monoclonal antibody (IgG2λ), indicated for the add-on maintenance treatment of adult and pediatric patients aged 12 years and older with severe asthma.

☐ If patient is switching biologic therapies such as Fasenra™, Xolair®, Cinqair®, or Nucala®, then MD must specify wash-out period prior to starting **TEZSPIRE™** as specified of _____ weeks. Last known therapy _____ and last known date received _____ .

☐ Other as requested: _____

_____

_____

Warnings & Precautions

• Hypersensitivity Reactions: Hypersensitivity reactions (e.g., rash, allergic conjunctivitis) can occur after administration of TEZSPIRE. Initiate appropriate treatment as clinically indicated in the event of a hypersensitivity reaction. (5.1)• Risk Associated with Abrupt Reduction in Corticosteroid Dosage: Do not discontinue systemic or inhaled corticosteroids abruptly upon initiation of therapy with TEZSPIRE. Decrease corticosteroids gradually, if appropriate. (5.3)• Parasitic (Helminth) Infection: Treat patients with pre-existing helminth infections before therapy with TEZSPIRE. If patients become infected while receiving TEZSPIRE and do not respond to anti-helminth treatment, discontinue TEZSPIRE until the parasitic infection resolves. (5.4)• Vaccination: Avoid use of live attenuated vaccines.

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.