Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:			MRN:
☐ New referral	☐ Order change		☐ Order Renewal
Patient preferred clinic:			

Tezspire™ (tezepelumab-ekko) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:	Patient's Phone:
Patient Name:	Address:
Date of Birth:	City, State, Zip:
Height in inches: / Weight: LB or KG	Gender: / Allergies: ☐ See list ☐ NDKA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

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

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	Include any lab results/and or Pulmonary Function Tests to support diagnosis

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:	IF YES:
PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INJECTION DATE:
	NEXT INJECTION DATE:
	IF ORDER CHANGE:
	☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

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.

MEDICATION/DOSE:

☑ Tezspire™ (Tezepelumab-ekko) 210mg via subcutaneous injection.

Administer subcutaneously to upper arm, thigh, or abdomen

FREQUENCY:

- ☐ Every 4 weeks
- ☐ Other:________________________________

SPECIAL ORDERS:

☐ ________________________________

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

- ☑ Start PIV/Access CVC
- ☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)

		DATE
Dispense as written/Brand medically necessary	Substitution permitted	