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:

PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:

LAST INJECTION DATE:

NEXT INJECTION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

Provider Attestation for HCP administration:

☐ Provider attestation that the patient or caregiver are not competent or are physically unable to administer the Tezspire™ product FDA labeled for self-administration

☐ Patient has a history of uncontrolled disease and ordering provider attests that in their clinical opinion, it is not advisable to try the self-administered formulation of requested drug

☐ The location and circumstances for self-administration are not adequate for the potential treatment of anaphylaxis should that arise.

☐ Patient has experienced severe hypersensitivity reactions (e.g., anaphylaxis, angioedema, bronchospasm, or hypotension) to Tezspire™ within the past 6 months and requires administration and direct monitoring by a healthcare professional*

☐ Due to patient's weight, ordering provider attests that in their clinical opinion, it is not advisable to try the self-administered formulation of requested drug

*Specific reactions: _____

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

SPECIAL ORDERS:

☐ _____

☑ Refills x 12 months unless noted otherwise here:

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	