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

Rev 4.29.25

PATIENT DEMOGRAPHICS:

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

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:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INJECTION DATE:
3	Full medication list		NEXT INJECTION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	Include any lab results/and or Pulmonary Function Tests to support diagnosis		☐ **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.

DOSE/FREQUENCY:

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

Administer subcutaneously to upper arm, thigh, or abdomen

OTHER FREQUENCY:

☐ _____

SPECIAL ORDERS:

☐ _____

☑ Refills x 12 months unless noted otherwise here:

CARE ORDERS:	ADVERSE REACTION & ANAPHYLAXIS ORDERS:
☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated.	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website.

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	