

Tezepelumab-ekko (Tezspire)

Provider Order Form rev. 3/1/2023



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PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ DOB: _____

ICD-10 code (required): _____ ICD-10 description: _____

NKDA Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

NURSING

- Provide nursing care per 360 Infusion Center Nursing Procedures, including reaction management and post-procedure observation

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

- Tezepelumab-ekko** (Tezspire)
- Dose: 210 mg/1.91 mL (110 mg/mL) solution
 - Route: subcutaneous injection
 - Frequency: once every four weeks

- Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

Provider Name (Print)

Provider Signature

Date