

# TEZSPIRE Injection Order (tezepelumab-ekko)



Fax completed order to: 334-521-0394

InfusionCare.org  
P: 334-521-0073

**\*Please fax a copy of the**  Demographics  Insurance Information  Current Medications  
**following patient information:**  H & P Relevant to the Diagnosis

This information is necessary for prior authorization approval and to ensure payment by the insurance carrier.

## Patient Information

Date of Referral

First Name

M.I.

Last Name

Date of Birth

Address

City

State

Zip Code

Phone

Wt (kg)

Ht (in)

Diagnosis

J45.50 Severe Persistent Asthma, Uncomplicated

J45.51 Severe Persistent Asthma with (acute) exacerbation

Other orders or special instructions

Office Contact Person

Office Contact Email or Phone Number

## TEZSPIRE Dosing

Administer 210 mg subcutaneous injection once every 4 weeks.

Quantity Dispense: \_\_\_\_\_ Refill: \_\_\_\_\_ times

\*PER OUR PROTOCOL, Patient will be monitored for 10 mins after injection.

## Prescribing Provider

Address

City

State

Zip Code

Provider Phone

Provider Fax

Provider NPI

Provider Tax ID

**PROVIDER SIGNATURE (No STAMPS)**

Date/Time