

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____
Date of Birth: _____ Address: _____
Allergies See List NKDA City, State, Zip: _____
Weight: _____ kg lbs Height: _____ in cm Email: _____

PRIMARY DIAGNOSIS

Severe persistent asthma, uncomplicated (J45.50)

Severe persistent asthma with (acute) exacerbation (J45.51)

Other: _____

PRESCRIPTION

Tezspire 210mg subcutaneously every 4 weeks x 1 year

Has patient received any doses of this medication in the past? Yes No

REQUIRED DOCUMENTATION

- Insurance Card
- Patient Demographics
- Most Recent Labs
- H&P
- Tried/Failed Therapies
- Medication List

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol
(See aiscaregroup.com for detailed policy)

- Epinephrine (weight-based dosing) PRN per protocol

Other: Please fax other reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

Per infusion center protocol: No recommended pre-medications for Tezspire.

Provider Prescribed: _____

LAB ORDERS—PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____
NPI: _____ Fax: _____
Office Contact Person: _____ Email: _____
Prescriber Signature: _____ Date: _____
I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.