

TEZSPIRETM

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

Please Send a Copy of The Patient's Up-to-Dat Clinical Notes

PATIENT INFORMATION (Co	mplete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name:	DOB:	Prescriber Name:
Address:		State License:
City, State, Zip:		NPI #: DEA:
Phone: /	Alt. Phone:	Address:
Email:	SS#:	City, State, Zip:
Gender: \square M \square F Weight:	(lbs) Ht:	Phone: Fax:
Allergies:		Office Contact: Phone:
INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)		
Primary Insurance:		Secondary Insurance (If Applicable):
Plan #:		Plan #:
Group #:		Group #:
		RX Card (PBM):
BIN:	_ PCN:	BIN: PCN:
CLINICAL INFORMATION		
☐ J45.50 Severe persistent asthma, uncomplicated ☐ J45.51 Severe persistent asthma with (acute) ☐ Other:		
Is Patient Receiving Medium to High Dose Corticosteroids? 🗆 Yes 🗀 No (If Yes, Please List Medication):		
Is Patient Receiving an Additional Controller Medication?		
☐ History of positive skin or specific IgE (test to perennial aeroallergen)		
Absolute Eosinophil Count: cells/mcL Pre-treatment serum lgE level: IU/mL		
Number of severe asthma exacerbations in the past 12 months: Number of ED visits or hospitalizations in the past 12 months:		
TRIED AND/OR FAILED MED		OF THERAPY REASON FOR DISCONTINUATION
TRIED AND/OR FAILED WILD	ICATIONS ELIVOTI	TOF THERAFT REASON FOR DISCONTINUATION
	/	
	/	/
TETCOLOFIM CORDERS		
TEZSPIRE™ ORDERS	_	
Prescription type: New start	T	Total Doses Received: Date of Last Injection:
Medication	Dose/Frequency	Quantity/Refills
☐ Tezspire™ (tezepelumab-ekko)	\square 210 mg/1.91 mL every 4 weeks	☐ 1-month supply ☐ Other:
210mg/1.91mL (110 mg/mL)	☐ Other:	Refills:
Medication	Dose/Frequency	Directions
☐ Acetaminophen	□ 500mg	☐ Take 1-2 tablets PO prior to infusion or post-infusion as directed
☐ Diphenhydramine	☐ 25mg IV/PO	\square Take 1 tablet PO prior to infusion or as directed OR
	☐ 50mg IV/PO	\square Inject contents of 1 vial IV prior to infusion or as directed
☐ Methylprednisolone	☐ 40mg ☐ 100mg	☐ Inject contents of 1 vial IV prior to infusion or as directed
	☐ 125mg	☐ Other: Inject 100mg IV 30 minutes prior to infusion
		and the state of t
INFUSION REACTION ORDER		— — — — — — — — — — — — — — — — — — —
		— — — — — — — — — — — — — — — — — — —

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Please Send a Copy of The Patient's Up-to-Dat Clinical Notes If symptoms worsen, see orders for moderate to severe reactions. Moderate reaction protocol: ☐ Acetaminophen 650mg PO, one time, for pyrexia or rigors ☑ Diphenhydramine 50mg IV, one time, for pruritus or urticaria ☑ Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms If symptoms worsen, see interventions for severe reactions Severe reaction protocol: (Call 911 if initiated): ☑ Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%) ☑ Diphenhydramine 50mg IV,one time, for respiratory symptoms, edema, or anaphylaxis Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis ☑ Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms Epinephrine 0.3mg/0.3mL IM into mis-anterolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen **FLUSHING & LOCKING ORDERS** Flushing Protocol (>66lbs/33kg) PIV and Midline: Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter: ☑ 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion ☑ 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw Locking Protocol (>66lbs/33kg) PIV and Midline: PICC: Implanted Port, Tunneled Catheter, and Non- □ Heparin Sodium 10 units/mL 1mL IV final □ Heparin Sodium 10 units/mL 3mL IV final tunneled Catheter: ☐ Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush flush post normal saline flush flush post normal saline flush ** May substitute Dextrose 5% in Water, or alternative, for 0.9& Sodium Chloride, when indicated due to incompatibility with medications bring infused **SIGNATURE** We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

Prescriber Signature

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