Tezspire Injection Order

Fax 888 511-7654 Phone 888 864-7341

Patient Name: ______________________ **DOB:** ______________________
Patient Phone: ______________________ **SEX:** M F

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

J45.50 Severe persistent asthma, uncomplicated

J45.51 Severe persistent asthma with (acute) exacerbation

Other ______________

ICD-10 ______________________

Patients weight: __________
Lab Date: ______________________
Allergies: ______________________

ALSO INCLUDE...

Clinical/ Progress Notes

Demographics Sheet

Current Medications

Labs

TEZSPIRE ORDER

Tezspire Dose: 210 mg/ 1.91 mL prefilled syringe

Frequency: Once every 4 weeks

Pre-treatment EOS serum: ___________cells/uL

Date of last Tezspire Injection:

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: ______________________ **Phone:** ______________________

Practice Address: ____

Office Contact: ______________________ **Fax:** ______________________

NPI/ TIN: ______________________

Referring Physician's Signature______________________ **Date:** __________