TEZEPELUMAB (TEZSPIRE®) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
Address:		
Phone:	**Height:** ☐ Inches ☐ cm	**Weight:** ☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:
Allergies: ☐ NKDA OR (List):	

Medication Order

☐ 210 mg administered subcutaneously once every 4 weeks

- ☐ Prefilled syringe for healthcare provider administration
- ☐ Prefilled pen for self-administration after patient or caregiver training and education provided

☐ Other: _____

Dispense refills x 1 year

Ancillary Orders

Anaphylaxis Kit

If this is a 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

☐ Yes ☐ No

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.
- Skilled Nursing to establish peripheral IV access as needed to manage anaphylaxis.

Lab Orders

☐ No labs ordered at this time.
☐ Other: _____

Skilled nurse to assess and administer as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy and skilled nursing plan of treatment will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:	Phone:	Fax:
Address:	**NPI:**	
City, State:	**Zip:**	**Office Contact:**

Fax completed form, insurance information, and clinical documentation to: 713-983-4647

