

TEZEPelumAB (TEZSPIRE®) PRESCRIBER ORDER FORM					
Patient Name:			Date of Birth:		Gender:
Address:					
Phone:		Height:	<input type="checkbox"/> Inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg
Clinical Information					
Primary Diagnosis Description:				ICD-10 Code:	
Allergies: <input type="checkbox"/> NKDA OR (List):					
Medication Order					
<input type="checkbox"/> 210 mg administered subcutaneously once every 4 weeks <div style="margin-left: 20px;"> <input type="checkbox"/> Prefilled syringe for healthcare provider administration <input type="checkbox"/> Prefilled pen for self-administration after patient or caregiver training and education provided </div> <input type="checkbox"/> Other: _____					
Dispense refills x 1 year					
Ancillary Orders					
Anaphylaxis Kit If this is a 1 st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1 st dose? <div style="margin-left: 20px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <ul style="list-style-type: none"> 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 <input type="checkbox"/> No labs ordered at this time. <input type="checkbox"/> 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>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>					
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					
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