

TEZEPLEMAB (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 <ul style="list-style-type: none"> <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 <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? <ul style="list-style-type: none"> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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. <input type="checkbox"/> Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (< 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement. <input type="checkbox"/> 0.9% Sodium Chloride 500 mL (> 30 kg) or 250mL (< 30 kg) IV at KVO rate PRN anaphylaxis. <input type="checkbox"/> 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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