

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 <ul style="list-style-type: none"> <li><input type="checkbox"/> Prefilled syringe for healthcare provider administration</li> <li><input type="checkbox"/> Prefilled pen for self-administration after patient or caregiver training and education provided</li> </ul> <input type="checkbox"/> Other: _____				
Dispense refills x 1 year				
Ancillary Orders				
<b>Anaphylaxis Kit</b>				
If this is a 1 <sup>st</sup> dose, would you like Option Care Health to provide an anaphylaxis kit with the 1 <sup>st</sup> dose?				
<input type="checkbox"/> Yes <input type="checkbox"/> No <ul style="list-style-type: none"> <li>▪ Epinephrine 0.3 mg (&gt; 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (&lt; 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.</li> <li>▪ Diphenhydramine 25 mg (&gt; 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.</li> <li>▪ 0.9% Sodium Chloride 500 mL (&gt; 30 kg) or 250mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.</li> <li>▪ Skilled Nursing to establish peripheral IV access as needed to manage anaphylaxis.</li> </ul>				
<b>Lab Orders</b>				
<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				
<small><b>CONFIDENTIAL HEALTH INFORMATION:</b> Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. <b>IMPORTANT WARNING:</b> This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.</small>				

Not valid for use for patients residing in Arizona, New York, and Wisconsin