

**PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX:  M  F HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_  LBS  KG

ALLERGIES: \_\_\_\_\_ PREFERRED CLINIC: \_\_\_\_\_

REFERRAL STATUS:  NEW REFERRAL  ORDER CHANGE  ORDER RENEWAL

**DIAGNOSIS & CLINICAL DOCUMENTATION**

- J33.0 Polyp of nasal cavity
- J33.1 Polypoid sinus degeneration
- J33.8 Other polyp of sinus
- J33.9 Nasal polyp, unspecified
- ICD-10 CODE: \_\_\_\_\_ DESCRIPTION: \_\_\_\_\_
- J45.50 Severe persistent asthma, uncomplicated
- J45.51 Severe persistent asthma with (acute) exacerbation

**REQUIRED DOCUMENTATION**

- Insurance Information
- List of Medications
- Tried & Failed Therapies
- Most Recent History & Physical
- Lab results and/or Pulmonary Function Tests to support diagnosis

**MEDICATION ORDER**

Tezspire® (tezepelumab) 210mg via subcutaneous injection every 4 weeks

COMMENTS: \_\_\_\_\_

REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: \_\_\_\_\_

**Provider Attestation of need for HCP administration**

(may be required by insurance)

- \_\_\_\_\_  
INITIALS Patient has experienced severe hypersensitivity reactions to Tezspire within the past 6 months and requires administration and direct monitoring by a healthcare professional.
- \_\_\_\_\_  
INITIALS Patient or caregiver are not competent or are physically unable to administer the Tezspire formulation labeled for self-administration.
- \_\_\_\_\_  
INITIALS Patient has history of uncontrolled disease and in the clinical opinion of the ordering provider, it is not advisable to try the self-administered formulation of Tezspire.
- \_\_\_\_\_  
INITIALS The circumstances and location for self-administration are not adequate for the potential treatment of anaphylaxis.
- \_\_\_\_\_  
INITIALS Patient's weight is such that in the clinical opinion of the ordering provider, it is not advisable to try the self-administered formulation of Tezspire.

In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol. Administer per protocol.

**PRESCRIBER INFORMATION**

PROVIDER NAME: \_\_\_\_\_ NPI #: \_\_\_\_\_

EMAIL: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

ADDRESS (INCLUDE CITY, STATE, ZIP): \_\_\_\_\_

SUPERVISING PHYSICIAN: \_\_\_\_\_ CONTACT NAME: \_\_\_\_\_  
(IF APPLICABLE)

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN