



# Tezspire (tezepelumab-ekko) Injection Orders

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female

Diagnosis (please provide ICD10 code) \_\_\_\_\_

NKDA Allergies: \_\_\_\_\_

New Start Therapy       Continuation of Therapy      Date of last dose (if applicable): \_\_\_\_\_

## Ordering Provider:

Provider NPI: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## HISTORY

Previous Drug Therapy History/Therapies Tried and Failed:

Xolair       Nucala       Cinqair      Other: \_\_\_\_\_

Date of last dose: \_\_\_\_\_

## REQUIRED LABS

Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (please attach)

## TEZSPIRE ORDERS

### DOSING/FREQUENCY:

Dose: 210 mg/1.91 mL (110 mg/mL) solution

Route: subcutaneous injection

Frequency: once every four weeks

### REFILLS:

\_\_\_\_\_  
(if not indicated prescription will expire one year from date signed)

### Infuse One Standing Orders:

Provide treatment under Infuse One's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

\_\_\_\_\_  
Provider Name

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date