INTRAMED Plus
infusion services

TEZSPIRE®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ Severe persistent asthma, uncomplicated ICD-10 Code: J45.50
_____ Severe persistent asthma with acute exacerbation ICD-10 Code: J45.51
_____ Other:_____ ICD-10 Code: _____

Allergies:_____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
  - Include any labs or other diagnostic results to support diagnosis (i.e. PFTs)
  - Documentation of previous therapies trialed and outcomes (i.e. treatment failure, intolerance, etc.)
  - Medication List

Patient
Weight: _____ lbs.
Height: _____ in.

TEZSPIRE® (tezepelumab-ekko) J Code: J2356

4. Drug Order:

Administer 210 mg Tezspire subcutaneously every four (4) weeks _____# Refills (Recommend 5 Refills)

❑ Wash Out Orders (please check if indicated) :
If the patient is transitioning from an alternative biologic such as Cinqair®, Fasenra®, Nucala®, Xolair® please indicate the desired washout period from the last dose of the prior therapy: _____ weeks

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

FAX ALL INFORMATION CENTRAL FAX **803.999.1754**	**INFUSION CENTER LOCATIONS** **BERKELEY CHARLESTON COLUMBIA GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**