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.

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### 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 INTAKE PHONE |
|---|---|
| CENTRAL FAX **803.999.1754** | **803.999.1750** |