Tezspire

INFUSION FOR HEALTH
InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

PROVIDERS: Please include the following to expedite the order.
Most Recent Office Visit Note, Insurance, Medication List *Not indicated for patients with known Helminth Infection*
Number of severe asthma exacerbations in the past 12 months: _____
Number of ED visits or hospitalizations in the past 12 months: _____

PATIENT INFORMATION

Patient Name: _____
DOB: _____
Allergies: _____
Weight: _____ lbs / kg Height: _____
Diagnosis: ☐ J45.50, ☐ J45.51
Other Dx/ICD10: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
Signature: _____
NPI: _____ Date: _____
Phone: _____ Fax: _____
Office Address: _____
Contact Person: _____
Contact Email: _____

The following medications will be administered per prescribing information:

☐ No Premeds **Center will use Hypersensitivity protocol established by Infusion for Health and P.I**

Lab Orders: ☐ List: _____
☐ Prior to first appointment ☐ Other Frequency: _____

TEZSPIRE DOSAGE

Date of Last Treatment, If Continuation:

Dose: 210 mg/1.91 mL (110 mg/mL) solution in a single-dose pre-filled syringe
Frequency: Once every 4 weeks **Other:** _____
Start Date: _____ **Route**: ☑ SQ

To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Infusion for Health is authorized to administer generic or biosimilar.

☐ Please check this box if you **DO NOT** authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

☐ Please check this box if you **DO NOT** authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.