



Web: www.AgileIV.com | Tel: (201) 751-2202 | Fax: (201) 266-0437 | Email: info@AgileIV.com

TEZSPIRE MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ DOB _____

Patient's height in feet and inches _____ Patient's weight in pounds _____

■ Diagnosis

- J45.50 Severe persistent asthma uncomplicated
- J45.51 Severe persistent asthma with (acute) exacerbation
- J45.52 Severe persistent asthma with status asthmaticus
- _____

■ Details Needed for Approval *Please answer all questions and provide supporting documentation.*

- What type of asthma (allergic, steroid-dependent, eosinophilic, etc) does the patient have? _____
- Does the patient have asthma symptoms throughout the day? _____
- Does the patient get awoken during the night due to asthma symptoms? _____
- Does the patient use SABA for symptom control several times per day? _____
- Does the patient have extremely limited normal activities due to severe asthma? _____
- What is the patient's lung function as a percent of predicted FEV1? _____
- Are the patient's exacerbations requiring systemic steroids generally more frequent / intense relative to moderate asthma? _____
- Does the patient's asthma get worse when inhaled or systemic steroids are tapered? _____
- Will Tezspire be used as an add-on to medium-to-high dose inhaled corticosteroids? _____
- Will Tezspire be used in addition to other controller medication (ie. long-acting beta agonist, leukotriene modifier, etc) ? _____
- Will Trespire be prescribed another biologic concurrently with Tezspire? _____
- Has the patient had ≥ 2 exacerbations in the past year requiring oral or injectable steroid treatment? _____
- Has the patient had ≥ 1 exacerbation requiring hospitalization in the past year? _____
- Does the patient have any history of unacceptable toxicity to Tezspire? _____
- Has the patient failed on or contraindication to Xolair, Cinqair, Dupixent, Fasenna or Nucala? _____ *If yes, please provide details.*
- Is Tezspire being prescribed for acute bronchospasm or status asthmaticus? _____

■ Medication Order

Select only one dosage regimen. 28 days of oral medication lead-in to be handled by prescriber and patient's pharmacy separately.

- 210mg/1.91ml Tezspire PFS (tezepelumab-ekko) administered subcutaneously once every 4 weeks for _____ months.

Medication shall be brought to room temperature before injection. Administer according to manufacturer instructions. Check vitals and monitor for signs and symptoms before administration and after completion.

■ Rescue Management in Case of Reaction

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.
- Call ordering provider to report reaction.

■ Ordering Provider Authorization

Provider Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ Indiv. NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone to Contact Person: _____

Documentation to Include:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.