TEZSPIRE
(tezepelumab-ekko)

FLOURISH™ HEALTH GROUP

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List •Tried/Failed Therapies

PRIMARY DIAGNOSIS

☐ J45.50 Severe persistent asthma, uncomplicated
☐ J45.51 Severe persistent asthma with (acute) exacerbation
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

_____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Tezspire
☐ Provider Prescribed: _____

_____

PRIMARY MEDICATION ORDER

☐ Tezspire 210 mg SubQ injection every 4 weeks.
☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Flourish Health Group's protocol
(See flourishhealth.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date