Phone: (877) 246-9104
Fax: (800) 783-9146
www.Biotekrx.com

Tezspire Referral Form

PATIENT INFORMATION

Name_____DOB _____
Address _____
City_____ State_ Zip_____
Phone _____ Alt. Phone _____
Email _____Gender M F

PHYSICIAN INFORMATION

Name_____ NPI_____
Address _____
City _____
State Zip _____ Phone _____
Fax_____
Office Contact _____ Phone_____

REQUIRED ✓Insurance Card Front/Back ✓Prescription Insurance Card Front/Back ✓Clinical Notes ✓Lab/Test Results

CLINICAL INFORMATION

☐ J45.50 Severe persistent asthma, uncomplicated ☐ J45.51 Severe persistent asthma with acute exacerbation

Other ICD-10 Code:_____Diagnosis Description:_____

Drug Allergies_____ Latex Allergy Yes No Height_____(in) Weight _____(lbs)

Is pt. receiving medium to high dose corticosteroids? Yes No (If Yes, please list medication): _____

Is pt. receiving an additional controller medication? Yes No (If Yes, please list medication): _____

Did pt. have an exacerbation causing ED visit or hospitalization? Yes No Baseline FEV_1: _____ Date: _____

TRIED AND/OR FAILED MEDICATIONS | LENGTH OF THERAPY | REASON FOR DISCONTINUATION

_____ / _____ / _____

_____ / _____ / _____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
☐ Tezspire (Tezepelumab-ekko))	210mg Vial/PFS	Inject 210mg SC every 4 weeks		
☐ Other:				

PRE-MEDICATION	DOSE/STRENGTH	DIRECTIONS
☐ Acetaminophen	☐ 500mg	Take 1-2 tablets PO prior to infusion or post-infusion as directed
☐ Cetirizine	☐ 10mg	Take 1 tablet PO prior to infusion or as directed
☐ Diphenhydramine-IV	☐ 25mg ☐ 50mg	Inject contents of 1 vial IV prior to infusion or as directed
☐ Diphenhydramine-PO	☐ 25 mg ☐ 50 mg	Take 1 tablet PO prior to infusion or as directed
☐ Methylprednisolone	☐ 40mg ☐ 125mg	Inject contents of 1 vial IV prior to infusion or as directed
☐ Ondansetron ODT	☐ 4mg	Take 1-2 tabs prior to infusion or as directed
☐ Other		

Special Instructions:

Provider Signature X: _____ Date: _____