TEZSPIRE (TEZEPELUMAB) INJECTION ORDERS

P: 331-236-0610 | **F:** 331-314-8989

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 331-314-8989

Name:		DOB:		Gender: □ Female □ Male	
Address:		City:	State:	ZIP:	
Phone:	Email:	Height:	□ inches □ cm	Weight:	□ lbs. □ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: □ New to Therapy □ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:		Fax:	
Office Contact:				Email:	
Address:		City:	State:	ZIP:	
NPI #:	DEA#:			Tax ID:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:		Policy #:		Group #:	
Secondary Insurance:		Policy #:		Group #:	

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refills
Tezspire (tezepelumab)	□ 210mg SubQ every 4 weeks □ Other: _____	□ x 1 year □ _____

Other orders: _____

Lab Orders: _____ Frequency: _____

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. □ Dispense as written

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing *LIVbetter Infusions.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Prescriber Signature: X **Date:**

COMPREHENSIVE SUPPORT FOR TEZSPIRE (TEZEPELUMAB) THERAPY

PATIENT INFORMATION

Name: DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - ☐Please indicate any tried and failed therapies (if applicable):
    - ☐Corticosteroids _____
    - ☐Long acting beta 2 agonist _____
    - ☐Long acting muscarinic antagonist _____
    - ☐Leukotriene receptor antagonist _____
  - ☐Please indicate any that apply to the patient:
    - ☐Poor symptom control (ACQ score ⩾ 1.5 or ACT score consistently < 20)
    - ☐Two or more burst of systemic corticosteroids for at least 3 days each in the previous 12 months
    - ☐Asthma-related emergency treatment
    - ☐Airflow limitation (FEV1 < 80% predicted)
    - ☐Dependent on oral corticosteroids for asthma maintenance
- ☐ Include labs and/or test results to support diagnosis
  - ☐ Pulmonary Function Tests (asthma) **attach**
- ☐ Other medical necessity: _____