SOMC Cancer Center & Infusion
Ph: (740) 356-7490
Fx: (740) 356-7488

Tezepelumab (Tezspire)
Order Form

Once all of the requirements below have been completed and checked off, please call to schedule appointment at (740) 356-7490 and if non-SOMC provider fax all documents to (740) 356-7488. If you any questions or special needs, please discuss them at the time of scheduling. Thank you!

Name: ______________________ **Date of Birth:** ______________

Phone Number: Home ______________ Cell ______________ **Weight:** ________

Allergies: ____

Diagnosis:
☐ Primary Diagnosis ____

Tezspire Infusion Policy Prior Treatment Requirements:
- ☐ Insurance pre-certification confirmation prior to treatment
- ☐ Scheduled Treatment Date: ______________
- ☐ H & P or progress note within last 30 days prior to treatment and include failure of oral medication for osteoporosis. (Medicare)
- ☐ Prescription for Epi-Pen given to patient.

Order: Tezspire
- ☐ Tezspire subQ 210 mg
  Frequency: Every 4 weeks
  Refills: 12

Tezspire Co-Pay Assistance:
☐ Yes ☐ No ☐ If Yes - Copy of Copay Card Agreement faxed to AIC

Adverse Reaction:
- ☑ Benadryl 25 mg IV push x 1 for rash, hives or itching **<u>if no allergy exists</u>**
- ☑ Solumedrol 125 mg IV push x 1 for rash, hives or itching **<u>if no allergy exists</u>**
- ☑ Epinephrine (1:1000) 0.3 mg (0.3 mL) IM x 1 for Respiratory Distress
- ☑ O2 per oxymask to maintain O2 saturation above 94%
- ☑ Give all of the above medications for an anaphylactic reaction as evidenced by: swelling of tongue, lips, and throat, trouble breathing, wheezing, abdominal pain, vomiting, dizziness, rash, hive itching
- ☑ Anaphylaxis - Obtain an IV with 0.9% Normal Saline at KVO, notify ordering physician, and prepare to transfer to Emergency Department

Provider Signature:

DATE:	TIME:	SIGNATURE:

Printed Provider Name: ______________________________
Phone number of referring provider: **Phone #** ______________________
Fax number of referring provider: **Fax #** ______________________