Tezspire Injection Order

LivWell INFUSIONS

Fax 888 511-7654 Phone 888 864-7341

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

◯ J45.50 Severe persistent asthma, uncomplicated

◯ J45.51 Severe presistent asthma with (acute) exacerbation

◯ Other _____

ICD-10 _____

Patients weight: _____

Lab Date: _____

Allergies: _____

ALSO INCLUDE...

◯ Clinical/ Progress Notes

◯ Demographics Sheet

◯ Current Medications

◯ Labs

TEZSPIRE ORDER

Tezspire Dose: ◯ 210 mg/ 1.91 mL prefilled syringe

Frequency: ☐ Once every 4 weeks

Pre-treatment EOS serum: _____cells/uL

Date of last Tezspire Injection:

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____