



LivWell
INFUSIONS

Tezspire Injection Order

Fax 888 511-7654 Phone 888 864-7341

Patient Name: _____
Patient Phone: _____

DOB: _____
SEX: M F

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis: J45.50 Severe persistent asthma, uncomplicated
J45.51 Severe persistent asthma with (acute)
exacerbation
J33.0 Polyp of nasal cavity
J33.9 Nasal Polyp, unspecified
Other _____
ICD-10 _____

ALSO INCLUDE...

- Clinical/ Progress Notes
- Demographics Sheet
- Current Medications
- Labs
- Insurance Cards

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:** _____