

TEZSPIRE® (tezepelumab-ekko) Referral Form



Patient Preferred Clinic (select one):

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

DOB:	Patient Name:	Patient Phone:
Patient Address:	Patient Email:	
NKDA Allergies:	Weight (lbs/kg):	Height:
ICD-10 code (required):	ICD-10 description:	Last Treatment Date: Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

NURSING

Infusion to be administered per Vivo protocols.

TEZSPIRE THERAPY ADMINISTRATION

210 mg subcutaneously every 4 weeks

PREMEDICATIONS

acetaminophen (Tylenol) 500 mg 650 mg 1000 mg PO
cetirizine (Zyrtec) 10mg PO
loratadine (Claritin) 10mg PO
diphenhydramine (Benadryl) 25 mg 50 mg PO IV
methylprednisolone (Solu-Medrol) 40mg 125mg IV
hydrocortisone (Solu-Cortef) 100mg IV
Other: _____
Dose: _____ Route: _____

REQUIRED DOCUMENTATION

- Patient Demographics
- Insurance Card/Information
- Progress Notes Supporting DX
- Medication List and H&P

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print) **Provider Signature** **Date**

Fax Numbers

Virginia: 804-500-5941	Nevada: 702-489-5744	Massachusetts: 800-540-1852
Colorado: 303-418-4679	New Jersey: 609-955-3711	Pennsylvania: 215-399-9244
Florida: 904-930-4211	Ohio: 216-400-0674	New York: 800-540-1852
Texas: 469-340-0044	Oklahoma: 918-770-4421	Connecticut: 203-724-4838

Have a Question? (720) 902-4111
Email Referrals To: referrals@vivoinfusion.com
Email Specialty Referrals to: info@specialtyinfusion.com

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