TEZSPIRE (TEZEPELUMAB-EKKO)
Infusion Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: _____ **DOB:** _____ **Phone:** _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

Medical Information

Diagnosis: ☐ Severe persistent asthma, uncomplicated **ICD-10 Code:** J45.50

☐ Severe persistent asthma with acute exacerbation **ICD-10 Code:** J45.51

☐ Other _____ **ICD-10 Code:** _____

Patient Weight: _____ lbs. (required) **Allergies:** _____

Therapy Order

Tezspire: ☐ 210 mg subcutaneously every 4 weeks x1 year

Lab Orders: _____ **Lab Frequency:** _____

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

Other Orders: _____

Provider Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* 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.

Provider Name: _____ **Signature:** _____ **Date:** _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

☐ Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX

☐ Phoenix, AZ ☐ Other _____

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Hy-Vee health

COMPREHENSIVE SUPPORT FOR TEZSPIRE THERAPY

Patient Information

Patient Name: _____ **DOB:** _____

Required Documentation for Referral Processing & Insurance Approval

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's current 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)
    - ☐ 2 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 **(attach)**
- ☐ **Other Medical Necessity:** _____

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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