

Cumberland Vital Care

Fax Referral To:

(931) 456-4857

Direct Phone: (931) 456-0680

TEZSPIRE ORDER FORM

Date:	ICD-10 Code: _____
Patient Name:	Allergies: _____
Date of Birth:	Weight: _____ lbs OR _____ kg
Therapy Status	Provider Information
New Start <input type="checkbox"/> Continuing Therapy: Last Dose: _____	Ordering Provider: _____ Provider NPI: _____ Provider Phone: _____ Provider Fax: _____ Provider Address: _____

MEDICATION ORDER

<input type="checkbox"/> Tezspire	<input type="checkbox"/> Tezspire 210mg to be administered subcutaneously every four weeks per protocol. <input type="checkbox"/> Tezspire _____ mg to be administered every _____ weeks per protocol.	Refills x one year from date of signature unless indicated below. <input type="checkbox"/> _____ refills
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PRE-MEDICATIONS

<input type="checkbox"/> Acetaminophen: _____ ^{Oral} 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: 10 mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other _____	<input type="checkbox"/> Dexamethasone: _____ ^{IV} 4mg _____ 8mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Methylprednisolone 125mg <input type="checkbox"/> Hydrocortisone 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other _____
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LAB ORDERS (Please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

Surveillance lab ordering, and monitoring is the responsibility of the prescriber	(Please fax this signed order form, along with the following documents to 800-223-4063) <ul style="list-style-type: none">• History & Physical, Last Office Visit Note• Patient Demographics and Insurance Information• Medication List• Recent Lab Work
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By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Dispense as Written:	Substitution Allowed:
_____ Prescriber Name Date	_____ Prescriber Name Date