



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ DEA: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)	
Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION	
<input type="checkbox"/> J45.50 Severe persistent asthma, uncomplicated <input type="checkbox"/> J45.51 Severe persistent asthma with (acute) <input type="checkbox"/> Other: _____	
Is Patient Receiving Medium to High Dose Corticosteroids? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Please List Medication): _____	
Is Patient Receiving an Additional Controller Medication? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Please List Medication): _____	
<input type="checkbox"/> History of positive skin or specific IgE (test to perennial aeroallergen)	
Absolute Eosinophil Count: _____ cells/mcL Pre-treatment serum IgE level: _____ IU/mL	
Number of severe asthma exacerbations in the past 12 months: _____ Number of ED visits or hospitalizations in the past 12 months: _____	

TRIED AND/OR FAILED MEDICATIONS	LENGTH OF THERAPY	REASON FOR DISCONTINUATION
_____ / _____ / _____	_____ / _____ / _____	_____ / _____ / _____
_____ / _____ / _____	_____ / _____ / _____	_____ / _____ / _____

TEZSPIRE™ ORDERS		
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection: _____		
Medication	Dose/Frequency	Quantity/Refills
<input type="checkbox"/> Tezspire™ (tezepelumab-ekko) 210mg/1.91mL (110 mg/mL)	<input type="checkbox"/> 210 mg/1.91 mL every 4 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1-month supply <input type="checkbox"/> Other: _____ Refills: _____
Medication	Dose/Frequency	Directions
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> 500mg	<input type="checkbox"/> Take 1-2 tablets PO prior to infusion or post-infusion as directed
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 25mg IV/PO <input type="checkbox"/> 50mg IV/PO	<input type="checkbox"/> Take 1 tablet PO prior to infusion or as directed OR <input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed
<input type="checkbox"/> Methylprednisolone	<input type="checkbox"/> 40mg <input type="checkbox"/> 100mg <input type="checkbox"/> 125mg	<input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed <input type="checkbox"/> Other: Inject 100mg IV 30 minutes prior to infusion
<input type="checkbox"/> _____	_____	_____

INFUSION REACTION ORDERS
Mild reaction protocol:
<input checked="" type="checkbox"/> Diphenhydramine 25mg IV, one time, for pruritus.

CONFIDENTIALITY STATEMENT: This facsimile and documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender at the address and telephone number set forth herein and arrange for return or destruction of the material. In no event should such material be read by anyone other than the named addressee. except by express authority of the sender to the named addressee.



If symptoms worsen, see orders for moderate to severe reactions.

Moderate reaction protocol:

- Acetaminophen 650mg PO, one time, for pyrexia or rigors
- Diphenhydramine 50mg IV, one time, for pruritus or urticaria
- Famotidine 20mg IV, one time, for, for pruritus or urticaria
- Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms

If symptoms worsen, see interventions for severe reactions

Severe reaction protocol: (Call 911 if initiated):

- Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)
- Diphenhydramine 50mg IV,one time, for respiratory symptoms, edema, or anaphylaxis
- Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis
- Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms
- Epinephrine 0.3mg/0.3mL IM into mis-anterolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen

FLUSHING & LOCKING ORDERS

Flushing Protocol (>66lbs/33kg)

PIV and Midline:

- 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion

Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:

- 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw

Locking Protocol (>66lbs/33kg)

PIV and Midline:

- Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush

PICC:

- Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush

Implanted Port, Tunneled Catheter, and Non-tunneled Catheter:

- Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush

**** May substitute Dextrose 5% in Water, or alternative, for 0.9% Sodium Chloride, when indicated due to incompatibility with medications being infused**

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X _____

Prescriber Signature

Date: _____

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

CONFIDENTIALITY STATEMENT: This facsimile and documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender at the address and telephone number set forth herein and arrange for return or destruction of the material. In no event should such material be read by anyone other than the named addressee. except by express authority of the sender to the named addressee.