

Los Angeles, CA  
2080 Century Park East  
Suite 710  
Los Angeles, CA 90067

# ORDER FORM TEZESPIRE®

Date: \_\_\_\_\_

## PATIENT INFORMATION

|            |                   |  |
|------------|-------------------|--|
| Name:      | DOB:              | SEX: M <input type="checkbox"/> F <input type="checkbox"/> |
| Allergies: | Date of Referral: |  |

## PHYSICIAN INFORMATION

|                  |                      |
|------------------|----------------------|
| Physician Name*: | Practice Name:       |
| Address:         | Office Contact*:     |
| Phone: Fax:      | Email (for updates): |

## REFERRAL STATUS

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ Discontinuation Order

## TEZESPIRE\*:

\_\_\_\_\_ Dosing: 210mg subcutaneous every 4 weeks  
\_\_\_\_\_ Other

### Total Doses:

Yea \_\_\_\_\_  
Other \_\_\_\_\_  
Refill \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date (Order is Valid for One Year) \_\_\_\_\_

\*NPI # \_\_\_\_\_

Infusion will be administered per MPP policy and protocols

### ICD 10 Description:

### REQUIRED DOCUMENTATION CHECKLIST:

\_\_\_\_\_ Patient Demographics  
\_\_\_\_\_ Insurance Card/Information  
\_\_\_\_\_ Clinical/Progress Notes supporting DX  
\_\_\_\_\_ Current Medication List and H&P  
\_\_\_\_\_ Other

Last Infusion/Injection Date: \_\_\_\_\_

### NOTES/ADDITIONAL COMMENTS:

## ORDERING PROVIDER

Signature X \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_