



Please Fax Completed Form To: 888-340-3699

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

Please Send a Copy of The Patient's Up-to-Dat Clinical Notes

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"/> 25mg IV/PO	<input type="checkbox"/> Take 1-2 tablets PO prior to infusion or post-infusion as directed <input type="checkbox"/>
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 50mg IV/PO <input type="checkbox"/> 40mg <input type="checkbox"/> 100mg	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"/> 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
<b>Mild reaction protocol:</b>
<input checked="" type="checkbox"/> Diphenhydramine 25mg IV, one time, for pruritus.

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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
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):

- Titrating 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 mid-antrolateral 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 Infuse IQ 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.

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