Please fax both pages of completed form to your team at 866.531.1025.

To reach your team, call toll-free 866.839.2162.

You can now monitor shipments and chat online if you have questions. Go to <u>MyAccredoPatients.com</u> to log in or get started.

Prescription & Enrollment Form **Tezspire[™] (tezepelumab-ekko)**

accredo

Four simple steps to submit your referral.

1 _			
I P	atient	Information	
L 1.	aticit	mormation	

Current patient

New patient

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	Please
	and n

Please provide copies of front and back of all medical and prescription insurance cards.

Patient's first name	Last name	Middle initial
Sex at birth: Male Female Preferred pronouns	Last 4 digits of SSN	Date of birth
Street address		Apt #
City S	State	Zip
Home phone Cell phone	Email addres	SS
Parent/guardian (if applicable)		
Home phone Cell phone	Email addres	SS
Alternate caregiver/contact		
Home phone Cell phone		
OK to leave message with alternate caregiver/contact		
Patient's primary language: English Other If other, plea	ase specify	
2 Prescriber Information	All fields must be comple	ted to expedite prescription fulfillment.
Date Time	Date medication needed _	
Office/clinic/institution name		
Prescriber info: Prescriber's first name	Last name	
Prescriber's title	If NP or PA, under direction of	Dr
Office phone Fax	NPI #	License #
Office contact and title	Office contac	ct email
Office street address		Suite #
City	State	Zip
Infusion location: Patient's home Prescriber's office Infu	ision site. If infusion site, complete	information below dotted line.

Infusion info: Infusion site name		Clinic/hospital affiliation _		
Site street address			Si	uite #
City	State			Zip
Infusion site contact	Phone	Fax	_ Email	

3 Clinical Information

ICD-10 code (REQUIRED): Other		t asthma, uncomplicated	J45.51 Severe persis	tent asthma with (a	cute) exacerbation
NKDA Known drug a	llergies				
Prior anaphylactic reaction:	Yes (Reason/date) No
Concurrent meds					
Concomitant therapies:	Short-acting beta agonist	Long-acting beta agonis	t Antihistamines	Decongestants	Immunotherapy
Inhaled corticosteroid	Leukotriene modifiers	Oral steroids Nasal ste	roids Other		
Lab results: History of po	ositive skin OR RAST test	to a perennial aeroallergen			
Pre-treatment serum IgE leve	el IU per r	nL Test date	Pre-treatment seru	ım eosinophils	cells/mcL
and/or sputum eosinophils _	Date	Patient	wt kg	g Date wt obtained	
MD Specialty (required):	Allergist Pulmonologis	at ENT Primary care	Pediatrician Oth	ner	
Prescription type: Naïve/	new start Restart (Continued therapy			1

Prescription & Enrollment Form: Tezspire[™] (tezepelumab-ekko)

Patient's first name	Last name	Middle initial	Date of birth
Prescriber's first name	Last name	Phone	

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
Tezspire™ (tezepelumab)	210mg/1.91mL prefilled syringe	Inject 210mg under the skin every 4 weeks. Note: To be administered by a health care provider in a healthcare setting.	1-month supply 3-month supply Other:
	210mg/1.91mL prefilled pen	Inject 210mg under the skin every 4 weeks. Note: Can be shipped to patient or healthcare provider.	Refills

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE				
	Date	Dispense as written	Date	Substitution allowed

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.



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