### 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<sup>™</sup> (tezepelumab-ekko)**

accredo

Four simple steps to submit your referral.

1 _			
I P	atient	Information	
L 1.	aticit	mormation	

Current patient

New patient

$\frown$	
	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<sup>™</sup> (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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