Nevada Infusion
Reno Location - 5401 Longley Lane, Suite 34, Reno, NV 89511
Carson Location - 180 E. Winnie Lane, Carson City, NV, 89706
PH: 775-453-0667 | Fax: 775-470-8478

Tezspire Order Form

Patient Name: _____ DOB:_____
Phone:_____ Address: _____
City: _____ State:_____ Zip:_____ Email: _____
Sex: _____ Height: _____ Weight:_____ Allergies:_____

DIAGNOSIS:

- ☐ Severe persistent asthma, uncomplicated - ICD-10: J45.50
- ☐ Severe persistent asthma with acute exacerbation - ICD-10: J45.51
- ☐ Other_____ ICD-10:_____

ORDER FOR TEZSPIRE (tezepelumab-ekko):

- ☐ 210 mg subcutaneously every 4 weeks x 1 year
- ☐ Other Dosing: _____ Frequency:_____ x 1 year

PRE-MEDICATIONS:

- ☐ Acetaminophen 650mg PO
- ☐ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
- ☐ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☐ Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Subcutaneously
NURSING: Per Nevada Infusion

LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI:_____
Physician Signature: _____ Date:_____
Point of Contact: _____ Phone:_____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

Revised: 05/2026

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Patient Name: _____ DOB:_____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

☐ Signed provider orders (page 1)

☐ Patient demographic and insurance information

☐ Patient's current medication list

☐ Supporting recent clinical notes and H&P (to support primary diagnosis)

☐ Supporting documentation to include past tried and/or failed therapies, intolerance, benefits, contraindications to conventional therapy

☐ Please indicate any tried and failed therapies (if applicable):

- ☐ Corticosteroids _____
- ☐ Long acting beta 2 agonist _____
- ☐ Long acting muscarinic antagonist _____
- ☐ Leukotriene receptor antagonist _____

☐ Please indicate any that apply to the patient:

- ☐ Poor symptom control (ACQ score ≥ 1.5 or ACT score consistently < 20)
- ☐ Two or more burst of systemic corticosteroids for at least 3 days each in the previous 12 months
- ☐ Asthma-related emergency treatment
- ☐ Airflow limitation (FEV1 < 80% predicted)
- ☐ Dependent on oral corticosteroids for asthma maintenance

☐ Include labs and/or test results to support diagnosis

- ☐ Pulmonary Function Tests (please attach results)

☐ Other medical necessity: _____

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