BioPlus® Infusion

Fax your completed order to 877-734-1157

Patient Name: _____ DOB: _____ Date of Last Infusion: _____

Height_____ Weight_____

Infusion Location: (state and site)_____

Tezspire® (tezepelumab-ekko) Orders

Diagnosis (please provide ICD-10 code in space provided):

_____ Severe Persistent Asthma (ICD-10)

_____ Other: _____ (ICD-10)

Provider: Is patient required to carry epinephrine auto-injector?

- ☐ Yes, patient has been provided epinephrine auto-injector and has been educated on its use
- ☐ No, patient does not require epinephrine auto-injector

Nursing Orders:

-Hold Tezspire and notify provider if patient reports:

- current parasitic infection
- new or worsening asthma symptoms since initiating therapy
- Recent administration of live vaccines

-If indicated by provider above, confirm patient has epinephrine auto-injector and understands indications for use

☐ Tezspire 210mg Sub-Q every 4 weeks

-Record vital signs prior to discharge

-If patient develops bronchospasm, angioedema, hypotension, urticaria or other signs of anaphylaxis, initiate Hypersensitivity Reaction Management Protocol

Additional Orders:

Provider Name (print): _____ Date: _____

Provider Signature: _____ Time: _____

Order Reviewed 5/3/23. Order valid for one year unless otherwise indicated.