MIC | METRO INFUSION CENTER

INFUSION ORDERS- TEZSPIRE (Tezepelumab)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/

Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE	
☐ Severe persistent asthma, uncomplicated	ICD 10 Code: J45.50
☐ Severe persistent asthma w/acute exacerbation	ICD 10 Code: J45.51
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider ☐ Patient demographics AND insurance information	☐ Clinical/Progress notes supporting primary diagnosis ☐ Labs and Tests supporting primary diagnosis
List Tried & Failed Therapies, including duration of treatment: 1) 2)	

MEDICATION ORDERS			
Dosing	☐ 210mg subcutaneous every 4 weeks		
Refills:	☐ X 6 months	☐ X 1 year	☐ _____ doses

PHYSICIAN INFORMATION		
Prescribing Physician:		
Office Phone:	Office Fax:	Office Email:
Physician Signature:		Date:

Send a referral via fax at 866-507-1164 or email to the bionurses@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.