TwelveStone Health Partners
Fax Referral To: (615) 278-3355
Direct Phone: (844) 893-0012
Email: intake@12stonehealth.com

TEZSPIRE ORDER FORM

Date: _____ ICD-10 Code: _____

Patient Name: _____ Allergies: _____

Date of Birth: _____ Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ Provider Address: _____

Provider Phone: _____

ADMINISTRATION

Place of Administration:

☐ TwelveStone Infusion Center ☐ MD Office ☐ Other _____

MEDICATION ORDER

Tezspire

☐ Tezspire 210mg PFS to be administered subcutaneously every four weeks per protocol.

☐ Tezspire _____ mg PFS to be administered every _____ weeks per protocol.

Please fax order for Pre-Filled Pen to Tezspire Together 1-888-388-6016. **Twelvestone does not have access to Pens**

Refills for one year from date of signature unless indicated below.

_____ Refills

PRE-MEDICATIONS

Oral

☐ Acetaminophen: _____325mg _____500mg _____650mg
☐ Loratadine: 10mg
☐ Cetirizine: 10mg
☐ Diphenhydramine: _____25mg _____50mg
☐ Famotidine: _____20mg _____40mg
☐ Ibuprofen: _____ 200mg _____400mg _____600mg
☐ Ondansetron: _____4mg _____ 8mg
☐ Other: _____

IV

☐ Dexamethasone: _____4mg _____8mg
☐ Diphenhydramine: _____25mg _____50mg
☐ Famotidine: _____20mg _____40mg
☐ Methylprednisolone: 125mg
☐ Hydrocortisone: 100mg
☐ Ondansetron: _____4mg _____8mg
☐ Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written:

_____ _____
Prescriber Name Date

Substitution Allowed:

_____ _____
Prescriber Name Date

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