PINNACLE NEUROLOGY & INFUSION

Tezspire Injection Order Form

Patient Name: ______________________________ DOB: _____________________________________

Allergies:____

Height: ________________ Weight: ________________ (lb/kg) M____________ F_____________

ICD-10 Code (primary diagnosis) :____

Intravenous Access Device: (specify number of lumens) ______________________________

Tezspire Injectable 210 mg/ 1.91mL to be administered subcutaneously every 4 weeks for

__________________ *months (Refills x* _________ *months)*

Nursing & Laboratory Orders

Labs to be drawn: ____

Send lab results to: ____

Prescriber Signature: ____

Prescriber Printed Name: ____

Date: __________Phone:________________________________ Fax: ______________________________

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