OKLAHOMA INFUSION SERVICES

Tezspire Order Form

Please fax form to: 405-726-9849

Patient Information

Patient Name:	DOB:	Phone:	Gender: M ☐ F ☐
Patient Address:	Email:	Insurance:	

Additional Information Needed

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):
☐ J45.50 Severe Persistent Asthma, Uncomplicated
☐ J45.51 Severe Persistent Asthma with Acute Exacerbation
☐ J45.53 Eosinophilic Asthma
☐ Other: Code: __________ Description: ______________________________

Clinical Information:
☐ New Therapy Induction ☐ Therapy Continuation
☐ Patient Weight: __________ lbs / __________ kg ☐ Patient Height: __________ in / __________ cm
☐ Allergies: ______________________________
☐ Therapies Tried and Failed: ______________________________
☐ TB Test: Date: __________ Results: ____________________
☐ Forced Expiratory Volume (FEV1) Test? ☐ Yes ☐ No Date: __________ Results: ___________
☐ Perennial Aeroallergen Test? ☐ Yes ☐ No Test Date: __________ Results: __________________
☐ Has patient had pre-treatment IgE serum? ☐ Yes ☐ No Test Date: __________ Level: ______________________________
☐ Absolute Eosinophil Count: Date: __________ Level: ______________ cells/mcL
☐ Number of severe asthma exacerbations in the past 12 months: __________
☐ Number of ED visits or hospitalizations in the past 12 months: ___________

Lab Orders	Lab Orders to be done by
☐ CBC ☐ CMP ☐ ESR ☐ CRP ☐ Total IgE	☐ Oklahoma Infusion Services
☐ Other: ____________________________________	☐ Referring Provider

Prescription Information

☐ Tezspire	☐ Dose: 210 mg ≥ ages 12 years ☐ Frequency: every 4 weeks

Prescriber Information

Prescriber Name:		Office Contact Name:	
NPI #:	DEA #:	Contact Phone:	Contact Fax:

______________________________________ ____________________
Prescriber's Signature: Date:

By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.

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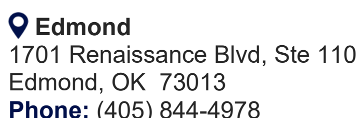
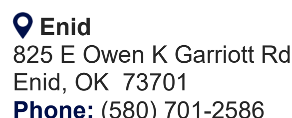
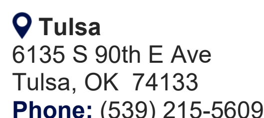

Edmond
1701 Renaissance Blvd, Ste 110
Edmond, OK 73013
Phone: (405) 844-4978


Enid
825 E Owen K Garriott Rd
Enid, OK 73701
Phone: (580) 701-2586


Tulsa
6135 S 90th E Ave
Tulsa, OK 74133
Phone: (539) 215-5609

www.okinfusion.com