TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

TEZSPIRE™

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____
NPI #: _____ DEA: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Office Contact: _____ Phone: _____

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____
City, State, Zip: _____
Plan #: _____
Group #: _____
Phone: _____

RX Card (PBM): _____
BIN: _____ PCN: _____
City, State, Zip: _____
Group #: _____
Phone: _____

Secondary Insurance (If Applicable):

Secondary Insurance: _____
Plan #: _____
Phone: _____

City, State, Zip: _____
Group #: _____

CLINICAL INFORMATION

☐ J45.50 Severe persistent asthma, uncomplicated ☐ J45.51 Severe persistent asthma with (acute) ☐ Other: _____

Is Patient Receiving Medium to High Dose Corticosteroids? ☐ Yes ☐ No (If Yes, Please List Medication): _____

Is Patient Receiving an Additional Controller Medication? ☐ Yes ☐ No (If Yes, Please List Medication): _____

☐ History of positive skin or specific IgE (test to perennial aeroallergen)

Absolute Eosinophil Count: _____ cells/mcL Pre-treatment serum IgE level: _____ IU/mL

Number of severe asthma exacerbations in the past 12 months: _____ Number of ED visits or hospitalizations in the past 12 months: _____

TRIED AND/OR FAILED MEDICATIONS	LENGTH OF THERAPY	REASON FOR DISCONTINUATION

TEZSPIRE™ ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection: _____

Medication	Dose/Frequency	Quantity/Refills
☐ Tezspire™ (tezepelumab-ekko) 210mg/1.91mL (110 mg/mL)	☐ 210 mg/1.91 mL every 4 weeks ☐ Other: _____	☐ 1-month supply ☐ Other: _____ Refills: _____

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X_____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.