

 St. Charles Health System Adult Ambulatory Infusion Order Tezepelumab-ekko (TEZSPIRE)	Patient Name: _____ Date of Birth: _____ <i>Patient Identification</i>
ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE	
Treatment Start Date: _____ Allergies: _____ Weight: _____ kg Height: _____ cm REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety 1. FACE SHEET with complete INSURANCE information and patient CONTACT information 2. Recent VISIT NOTE to support treatment (if not available in Epic) 3. LAB RESULTS for any required prescreening (if not available in Epic) 4. DIAGNOSIS CODE _____ 5. Patient NAME and DATE OF BIRTH on EVERY page faxed	

GUIDELINES FOR ORDERING :

1. Send FACE SHEET and H&P or most recent chart note.
2. Do not discontinue systemic or inhaled corticosteroids abruptly upon initiation of therapy with tezepelumab-ekko. Decrease corticosteroids gradually, if appropriate.
3. Treat patients with pre-existing helminth infections before therapy with tezepelumab-ekko. If patients become infected while receiving tezepelumab-ekko and do not respond to anti-helminth treatment, discontinue tezepelumab until the parasitic infection resolves.
4. Avoid use of live attenuated vaccines.

MEDICATIONS:

☐ tezepelumab-ekko (TEZSPIRE), 210 mg, subcutaneous, ONCE every 4 weeks, for _____ doses.

INFUSION MONITORING/REACTION:

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebule, AS NEEDED x1 dose for hypersensitivity reaction

☐ Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

**St. Charles Health System**

Adult Ambulatory Infusion Order
Tezepelumab-ekko
(TEZSPIRE)

Patient Name:

Date of Birth:

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Patient will be treated at the following infusion location:

- ☒ St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ License #: _____ Date: _____

Print Name: _____ Phone: _____ Fax: _____

Plan will expire 1 year after signature date at which time a new order will need to be placed