PARAGON HEALTHCARE
A Carelon Company

TEZSPIRE (TEZEPELUMAB-EKKO) INJECTION ORDERS

P: 877.365.5566 | **F:** 855.889.2946

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Severe Uncontrolled Asthma

- ☐ **J45.50** Severe persistent asthma, uncomplicated
- ☐ **J45.51** Severe persistent asthma, with acute exacerbation
- ☐ **J45.83** Eosinophilic asthma
- ☐ Other: _____

Chronic Rhinosinusitis with Nasal Polyps

- ☐ **J33.0** Polyp of nasal cavity
- ☐ **J33.1** Polypoid sinus degeneration
- ☐ **J33.8** Other polyp of sinus
- ☐ **J33.9** Nasal polyp, unspecified

Patient Weight: _____ lbs. (required) Allergies: _____

THERAPY ORDER

Tezspire: ☐ 210mg subcutaneously every 4 weeks x 1 year
(tezepelumab)

Lab Orders: _____ **Lab Frequency:** _____

Required labs to be drawn by: ☐ Paragon ☐ Referring Provider

Other orders: _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Paragon selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

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COMPREHENSIVE SUPPORT FOR TEZSPIRE (TEZEPELUMAB) THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - ☐ Please indicate any tried and failed therapies (if applicable):
    - ☐ Corticosteroids _____
    - ☐ Long acting beta 2 agonist _____
    - ☐ Long acting muscarinic antagonist _____
    - ☐ Leukotriene receptor antagonist _____
  - ☐ Please indicate any that apply to the patient:
    - ☐ Poor symptom control (ACQ score ≥ 1.5 or ACT score consistently < 20)
    - ☐ Two or more burst of systemic corticosteroids for at least 3 days each in the previous 12 months
    - ☐ Asthma-related emergency treatment
    - ☐ Airflow limitation (FEV1 < 80% predicted)
    - ☐ Dependent on oral corticosteroids for asthma maintenance
- ☐ Include labs and/or test results to support diagnosis
  - ☐ Pulmonary Function Tests (asthma) **attach**
- ☐ Other medical necessity: _____

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance