



Tezspire Order Form

Select patient referral location: Akron Athens Blue Ash Cleveland Columbus Crestview Hills
Dayton Mansfield Perrysburg Springfield Toledo West Cincinnati

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to 888-977-0914

Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:	DOB:
Phone:	Other Phone:
Email:	
Social Security #:	Allergies:
Gender: M F	Weight: Lbs Kg
Patient Status: New to therapy Continuing therapy	Next due date (if applicable):

2. INSURANCE INFORMATION (required)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:	NPI#:
License #: TIN#:	DEA#:
Address:	
City:	State Zip
Office Contact:	Email:
Office phone:	Office fax:

4. DIAGNOSIS INFORMATION (and year of diagnosis)

Severe Asthma () ICD 10 () Other: _____

5. PRESCRIPTION INFORMATION (requires new order every 12-months)

TEZSPIRE

Administer 210mg SubQ every 4 weeks

Vital signs per HI Protocol

Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS N/A

Acetaminophen	500mg	650mg	1000mg
Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)			
Diphenhydramine (Benadryl)	25mg	50mg	PO IV (requires driver)
Methylprednisolone (Solu-Medrol)	40mg	80mg	125mg IV
Prednisone	_____ mg PO		
Other _____			

POST-MEDICATIONS N/A

Acetaminophen	500mg	650mg	1000mg
Prednisone	_____ mg PO		
Other _____			

6. LABS

CBC w/Diff	Each Infusion	Other Frequency (specify): _____
CRP	Each Infusion	Other Frequency (specify): _____
CMP	Each Infusion	Other Frequency (specify): _____
ESR	Each Infusion	Other Frequency (specify): _____
Hepatic Panel	Each Infusion	Other Frequency (specify): _____
Renal Panel	Each Infusion	Other Frequency (specify): _____
Quantiferon TB Gold, annually, last completed (date): _____		
Other (specify): _____		

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE