Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

Tezspire Request Form

2301 Evesham Road, Building 800, Suite 115
Voorhees, New Jersey 08043
T. (856) 996-0145
F. (856) 770-8271 ~ Attn: Stephanie D

DATE:	
REFERRING PROVIDER INFORMATION	
Requesting Provider Name and NPI **Tax ID#**	**Name:** **NPI:** **Tax ID#**
Fax Number	
Practice Contact (Name/Phone number)	
We will gladly remind your patient to schedule routine follow-up visits with your office. **Return to Referring Provider (frequency): EVERY _____ WKS / MOS**	
PATIENT INFORMATION	
Patient Name	
Date of Birth	/ /
Height in ft/in: **Weight in lbs:**	
Insurance(s): include copies of front and back	
Preferred Treatment Location	▢ Voorhees ▢ Moorestown ▢ Wall/Manasquan ▢ Sewell ▢ Hamilton ▢ Galloway
Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:

Diagnosis:
☐ J45.50 Severe persistent asthma uncomplicated
☐ J45.51 Severe persistent asthma with (acute) exacerbation
☐ J45.52 Severe persistent asthma with status asthmaticus
☐ Other _____ _____

The following information is required for authorization for Tezspire:

- What type of asthma (allergic, steroid-dependent, eosinophilic, etc) does the patient have? _____
- Does the patient have asthma symptoms during the day? ☐ YES ☐ NO
- Is the patient awoken at night due to asthma symptoms? ☐ YES ☐ NO
- Does the patient use a SABA for control >1x/day? ☐ YES ☐ NO
- Are activities of daily life limited by asthma? ☐ YES ☐ NO
- Most recent FEV1 value? _____
- Does the patient suffer from frequent breakthrough symptoms or frequent exacerbations? ☐ YES ☐ NO
- Does the patient's asthma get worse when inhaled or systemic steroids are tapered? ☐ YES ☐ NO
- Will Tezspire be used as an add-on to medium-to-high dose inhaled corticosteroids? ☐ YES ☐ NO
- Will Tezspire be used in addition to other controller medications? ☐ YES ☐ NO
- Will Tespire be prescribed in conjunction with another biologic medicine? ☐ YES ☐ NO
- Has the patient had 2 exacerbations in the past year requiring oral or injectable steroid treatment? ☐ YES ☐ NO
- Has the patient had 1 or more exacerbation(s) requiring hospitalization in the past year? ☐ YES ☐ NO
- Does the patient have any history of unacceptable toxicity to Tezspire? ☐ NO
- Does the patient have a contraindication to (or previously failed treatment with) = Xolair, Cinqair, Dupixent, Fasenra or Nucala?
    - If yes, please provide details.

- Is Tezspire being prescribed for acute bronchospasm or status asthmaticus? ▫ NO

PLEASE NOTE:

- Please attach a copy of medication order to this document when transmitting to ARBDA/IDYLLIC. Prescription should include standard information as well as specific instructions if loading doses of desired RX is required.
    - ** NOTE ** Please do NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
- *OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS*
- *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*
- Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- **!! IMPORTANT !!** Please notify our office if the medication is discontinued.

Ordering Provider Signature: _____