Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral   ☐ Dose or Frequency Change   ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon   ☐ Effingham
*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Severe persistent asthma, uncomplicated   ICD 10 Code: J45.50
☐ Severe persistent asthma w/acute exacerbation   ICD 10 Code: J45.51
☐ Other: _____   ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider
☐ Patient demographics AND insurance information

*Patient may be required to submit a pregnancy test prior to treatment

☐ Clinical/Progress notes (must be within 1 year)
☐ Labs and Tests supporting primary diagnosis

List Tried & Failed Therapies, including duration of treatment:
1)
2)
3)

MEDICATION ORDERS

Dosing Wt for Calculations	Ht:	Wt:	BMI:

Dosing	☐ J2356 Tezspire 210mg subcutaneous every 4 weeks

Duration   ☐ X 6 months   ☐ X 1 year   ☐ _____ doses

ADDITIONAL ORDERS / INFORMATION

PRESCRIBER INFORMATION

Prescriber name :		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr.   Ph. 217-258-4150
Suite 204   Fax 217-348-2579
Mattoon, IL 61938

☐ EFFINGHAM
901 Medical Park Dr.   Ph. 217-342-7500
Suite 201   Fax 217-342-7499
Effingham, IL 62401

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INFUSION ORDERS - TEZSPIRE (Tezepelumab)

Clinics Scan to: Physician Orders