Please fax all pages of completed form to your team at 866.531.1025.
To reach your team, call toll-free 866.839.2162.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Accredo® Specialty Pharmacy Prescription & Enrollment Form

Tezspire™ (tezepelumab-ekko)

EVERNORTH HEALTH SERVICES

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ Last name _____ Middle initial _____

Preferred patient first name _____ Preferred patient last name _____

Sex at birth: ☐ Male ☐ Female Gender identity _____ Pronouns _____ Last 4 digits of SSN _____

Date of birth _____ Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email address _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify _____

Provider will read the following statement to patient: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Office/clinic/institution name _____

Prescriber info: Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact email _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site If infusion site, complete information below dotted line:

Infusion info: Infusion site name _____ Clinic/hospital affiliation _____

Site street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion site contact _____ Phone _____ Fax _____ Email _____

3 Clinical Information

ICD-10 code (REQUIRED): ☐ 45.50 Severe persistent asthma, uncomplicated ☐ J45.51 Severe persistent asthma with (acute) exacerbation ☐ Other _____

☐ NKDA ☐ Known drug allergies _____

Prior anaphylactic reaction: ☐ Yes (Reason/date _____) ☐ No

Concurrent meds _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

3 Clinical Information (cont.)

Concomitant therapies: ☐ Short-acting beta agonist ☐ Long-acting beta agonist ☐ Antihistamines ☐ Decongestants ☐ Immunotherapy ☐ Inhaled corticosteroid ☐ Leukotriene modifiers ☐ Oral steroids ☐ Nasal steroids ☐ Other _____

Lab results: ☐ History of positive skin OR RAST test to a perennial aeroallergen

Pre-treatment serum IgE level _____ IU per mL Test date _____ Pre-treatment serum eosinophils _____ cells/mcL and/or sputum eosinophils _____ Date _____ Patient wt _____ kg Date wt obtained _____

MD Specialty (required): ☐ Allergist ☐ Pulmonologist ☐ ENT ☐ Primary care ☐ Pediatrician ☐ Other _____

Prescription type: ☐ Naïve/new start ☐ Restart ☐ Continued therapy

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
Tezspire™ (tezepelumab-ekko)	☐ 210mg/1.91mL prefilled syringe	☐ Inject 210mg under the skin every 4 weeks. **Note: To be administered by a healthcare provider in a healthcare setting.**	☐ 1-month supply ☐ 3-month supply ☐ Other: _____ Refills _____
	☐ 210mg/1.91mL prefilled pen	☐ Inject 210mg under the skin every 4 weeks. **Note: Can be shipped to patient or healthcare provider.**	
☐ Other			

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

_____ _____ _____ _____

Date **Dispense as written** **Date** **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

EVERNORTH HEALTH SERVICES

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