



Fax Referrals To: (855) 891-2191  
 Email Referrals To: [referrals@vivoinfusion.com](mailto:referrals@vivoinfusion.com)  
 Have a Question? (855) 478-1528

TEZSPIRE™ (tezepelumab-ekko) ORDER FORM  
 (\* - Required Fields)

**STAT REQUEST**  
 (\*REASON MUST BE PROVIDED BELOW)

<b>New Referral</b>	<b>Referral Renewal</b>	<b>Medication/Treatment Change</b>
<b>Benefits Verification Only</b>		<b>Discontinuation Order</b>
<b>PATIENT INFORMATION</b>		
NAME*:	DOB*:	SEX: <input type="checkbox"/> M <input type="checkbox"/> F
ADDRESS:	PHONE:	
WEIGHT:      LBS   KG	HEIGHT:	EMAIL:
ALLERGIES:		
<b>PHYSICIAN INFORMATION</b>		
PHYSICIAN NAME*:	PRACTICE NAME:	
ADDRESS:	OFFICE CONTACT*:	
PHONE:	FAX:	EMAIL (FOR UPDATES):
TEZSPIRE Injection*: <i>(SELECT ONE OF THE FOLLOWING)</i>  210 mg subcutaneously every 4 weeks		
ICD-10*: _____		
Physician Signature* _____ Date*(Referral Valid for One Year) _____ *NPI # _____ <i>Infusion will be administered per VIVO policy and protocols</i>		
<b>ICD-10 Description:</b>	<b>REQUIRED DOCUMENTATION CHECKLIST:</b>	
*STAT REASON: (STAT requests will be assessed per VIVO policy and protocols)	Patient Demographics Insurance Card/Information Progress Notes supporting DX Current Medication List and H&P	
	Last Infusion/Injection Date: _____	
STANDING LAB REQUEST (to be drawn by clinic):	CMP	CBC *Frequency _____
Additional comments/notes:		

**Locations:**

-----Colorado-----

Lakewood

-----Florida-----

Jacksonville  
 Kissimmee  
 Port St. Lucie  
 Suncoast  
 Winter Park

-----Ohio-----

Beachwood  
 Middleburg Hts.  
 Painesville  
 Youngstown  
 Westlake  
 Fairlawn

-----Oklahoma-----

Tulsa

-----Texas-----

Arlington  
 Cedar Hill  
 Dallas  
 Denton  
 Ft. Worth  
 Irving  
 Rockwall  
 Southlake  
 Flower Mound  
 Plano  
 Tyler