Hematology-Oncology Associates of CNY

Conveniently Located in East Syracuse, Camillus & Auburn
Main Office Phone 315-472-7504
Nurse Navigator Phone 315-506-2469
Main Fax 315-634-5168

Patient Name: _____ **Height** (inches): _____

Date of Birth: _____ **Weight** (lbs): _____

Tezspire (tezepelumab-ekko)

Non-Oncology Treatment Order Set
Drug order form is valid for 12-months

Please complete *all fields* to facilitate timely intake and prior authorization processing.

1. **DIAGNOSIS** *MUST match recent office visit note*
   Please include an addendum or letter of medical necessity, if appropriate.

Severe Uncontrolled Asthma (SUA)
☐ J45.50 - Severe persistent asthma, uncomplicated
☐ J45.51 - Severe persistent asthma, with (acute) exacerbation
☐ J45.5 - Severe persistent asthma
☐ J82.83 - Eosinophilic asthma

Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
☐ J33.0 - Polyp of nasal cavity
☐ J33.1 - Polypoid sinus degeneration
☐ J33.8 - Other polyp of sinus
☐ J33.9 - Nasal polyp, unspecified

☐ ICD-10 Code: _____ Description: _____

DIAGNOSIS DATE: _____

2. **PRE-MEDICATION**
☐ Acetaminophen: ☐ 1000 mg PO ☐ 500 mg PO
☐ Diphenhydramine: ☐ 25 mg PO ☐ 50 mg PO ☐ 25 mg IV ☐ 50 mg IV
☐ Hydrocortisone: 100 mg IVP
☐ Other Pre-medication: _____
☐ No pre-medications indicated

3. **DRUG ORDER**
Tezspire (tezepelumab-ekko)

☐ 210 mg every 4 weeks via subcutaneous injection (to upper arm, thigh or abdomen)
☐ Wash-out period indicated:
Previous drug: _____ Last dose received: _____
Wash-out period (weeks): _____
☐ Other: _____

v2.0
05-05-2026

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Therapy Status

☐ **NEW** to therapy

☐ **Continuing** therapy-
Last dose received: Next dose due:

☐ Copy of *Medication Administration Record* is attached

4. REQUIRED LABS

☐ CBC with differential, annually

☐ Other:

☐ None indicated

****HOACNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION****

The **prescribing physician** is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.

5. LAB-INFUSION PARAMETERS

Our policy is to administer this medication as long as **white blood cell count** is within normal limits. If any additional monitoring parameters are required, *please specify below*:

6. COMPLETED BASELINE LABS & TESTS *Fax all results to HOACNY*

☐ CBC

☐ Other:

POLICY ACKNOWLEDGEMENT

To maintain ongoing authorization, updated clinical documentation is required every 6-months and a new drug order form is required annually. Updated documentation will be required for all dose and/or frequency changes.

HOACNY will obtain authorization for drug administration prior to scheduled infusion. If HOACNY is unable to obtain insurance authorization due to this medication not being in alignment with the insurance plan's medical policy, the referring office with be notified and HOACNY will not be able to administer the medication. HOACNY may use a biosimilar or generic medication based on insurance company's preferred biosimilar medications or practice preferred medications. The biosimilar medication used may change during the course of treatment depending on those preferences. HOACNY does not participate in free drug programs.

HOACNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation and management of hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. The prescribing physician is responsible for educating the patient of potential risks and complications associated with the drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Medication Infusion Services referral. The prescribing provider is responsible for identifying and managing any side effects of the prescribed medication and for determining whether it is appropriate to proceed with treatment. Please call our office to coordinate with our Infusion Services Nurse Navigator, as appropriate. Any changes in condition or delayed adverse events that occur after leaving the infusion center will be reported to the prescribing physician for evaluation & management.

Provider's Name: **Phone**:

Provider's Signature: **Date**: