



NEWPORT INFUSION TEZSPIRE REFERRAL FORM

1501 Superior Ave Suite 202 | Newport Beach
CA 92663 Ph 949-601-6001 | Fax 866-542-8631
NPI# 1184620866
newportinfusion.com

Today's Date _____
Date Needed _____

Patient Name _____ Date of Birth _____ ☐ Male ☐ Female
Address _____ Apt # _____ City _____ State _____ Zip _____
Telephone _____ Cell _____ SSN _____ Email _____
Allergies _____ Comorbidities _____

Current Medications (including OTC, if necessary, please fax a complete list) _____

Primary Insurance _____ ID# _____ Group # _____
Secondary Insurance _____ ID# _____ Group # _____
Insured's Name _____ Employer _____
City _____ State _____ Phone _____ Please attach patient's insurance cards, front and back

Diagnosis ☐ J45.50 Severe persistent asthma, uncomplicated ☐ J45.51 Severe persistent asthma with (acute) exacerbation
ICD-10 Code: ☐ Other _____

Patient currently on therapy? ☐ Yes ☐ No

Eosinophil count: _____ Cells/ μ L Date of test: ____/____/____ Number of asthma exacerbations
(requiring use of systemic corticosteroids and/or hospitalization)
in last 12 months: _____

PRESCRIPTION PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS (Front and Back)			
Medication	Directions	Quantity	Refills
Tezspire TM (tezepelumab)	☐ Inject 210mg subcutaneously every 4 weeks	☐ 1	1
		☐ Other: _____	2
			3
			4
			_____ # Refills

Administration Method (choose one): ☐ Prefilled Syringe (Office-Administered) ☐ Pen (Self-Administered)

Has the patient been started on samples? ☐ Yes ☐ No

Total number of TEZSPIRE (tezepelumab) doses received since start date: _____ Date of last injection/treatment: _____

Please attach the following: Most Recent Progress Notes & Lab Results & Medication List

Thank you!

Prescriber's Name / Practice _____ Office Contact _____
Address _____ Suite# _____ City _____ State _____ Zip _____
Tel _____ Fax _____ Email _____
License# _____ NPI# _____ UPIN# _____ DEA# _____

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

LEGAL NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. This prescription may be filled at a pharmacy of the patient's choice.

Please fax completed referral form to
Newport Infusion at (949)484-4150