MHS Home/Alternate Site Infusion Services
Tezepelumab (Tezspire) Injection Order Set

ALL ORDERS MUST BE SIGNED AND DATED BY PRESCRIBING PROVIDER

Patient Name:	**DOB:** ____/____/____	**Weight:** _____ lb/kg
Patient Phone Number: (_____) _____-_____	**Requested Date of Service:** ____/____/____	

Patient Allergies:

Diagnosis: _____   **ICD – 10 Code:** _____

Baseline Labs *(Required)*:
  PFTs   Date: ____/____/____   Result: _____

Additional Requirements: In addition to order, please include H&P with documentation to support diagnosis. Must include ICD-10 Code(s) and supporting labs. **** Emergency phone number for provider _____ (required) ***

Provider Order for Tezepelumab (Tezspire) Injection

ORDERS WITH CHECK BOXES	When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Biologic Injection:
  ☐   Tezepelumab (Tezspire) 210 mg SUBQ every 4 weeks

Skilled Nurse to draw labs as follows:
  ☐   Labs(s): _____   Frequency: _____

Skilled Nurse Interventions:
  - Admit *(first visit)* patient to services for home injection therapy of Tezepelumab (Tezspire).
  - Complete Skilled Nurse visit with each injection for ongoing home injection therapy of Tezepelumab (Tezspire).
  - Obtain vital signs (TPR & B/P) at baseline and post-injection.
  - Obtain patient weight at each visit.
  - Draw labs as ordered.
  - Inject Tezepelumab (Tezspire) as prescribed.
  - If vital signs are stable after injection, Skilled Nurse will complete visit.

If Hypersensitivity Reaction Develops (fever, chills, hypotension, rigors, itching, rash, etc.):
The Skilled Nurse will:
  - Administer emergency medications as prescribed (*below*).
  - Contact Emergency Medical Services (EMS/911) if indicated.
  - Increase vital sign monitoring to every 5 minutes.
  - Contact provider via emergency phone number for additional instructions.
  - Notify MHS Home/Alternate Site Infusion Pharmacist AND Nurse Supervisor.

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FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

Patient Identification:	Pre-printed order – Page 1 of 2
Name:	Tezepelumab (Tezspire) Order Set
MRN:	MultiCare
DOB:	

Emergency Medications: To be administered by skilled nurse as needed for hypersensitivity reactions.

- **Diphenhydramine 50 mg/mL solution:** Inject **0.5 mL** (25 mg) into the vein via slow IV push over at least 2 minutes as needed for rash, itching, hives, flushing of skin and/or mild-to-moderate hypersensitivity reaction. May give IM if no IV access is available.
- **Methylprednisolone sodium succinate (SOLU-MEDROL) 125 mg/2mL solution:** Inject **2 mL** (125 mg) into the vein as a slow IV push over at least 3 minutes once, as needed for hives, flushing of the skin, shortness of breath, chest tightness, tachycardia (HR>140bpm), and/or moderate-to-severe hypersensitivity reaction. May give IM if no IV access is available.
- **EPINEPHrine (Adrenalin) 1 mg/mL solution:** Inject **0.3 mL** (0.3 mg) intramuscular every 5-15 minutes as needed (maximum 3 doses) for severe allergic reaction or anaphylaxis AND call 911 and provider.
- **Acetaminophen (Tylenol) 325 mg tab:** Take **2 tablets** (650 mg) by mouth as needed for fever (PRN for temperature > 101F/38.3C) and/or mild-to-moderate hypersensitivity reaction.
- **0.9% NaCl (NS) solution:** Infuse **500 mL** into the vein via gravity as needed at a rate needed to maintain IV access.
- **Oxygen**: Initiate oxygen by RN PRN chest pain or dyspnea to keep SpO2>90%. For 1-6 LPM, use NC. For 6-10 LPM, use simple mask.

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: □ Yes □ No (if yes, please send DOCUMENTATION of consent with order)

I certify that this patient is safe and appropriate to receive therapy from Home Infusion Services.

Provider Signature: _____ **Printed Name:** _____ **Date:** _____

NPI: _____ Orders expire in 12 months unless otherwise specified: _____

Provider/Clinic Information:	**Return completed orders to:**
Address: _____	MultiCare Home/Alternate Infusion Services
	253-459-6650 (*phone*) / 253-864-2785 (*fax*)
Phone #: _____ Fax#: _____	

Patient Identification:	Pre-printed order – Page 2 of 2
Name:	Tezepelumab (Tezspire) Order Set
MRN:	MultiCare Revised 06/24
DOB:	