



INFUSION SUITE		TEZSPIRE INJECTION ORDERS	
Durango Infusion Center 270 E 8th Ave Ste N101 Durango, CO 81301		Phone: 970-828-3500	Fax: 970-828-3501
<b>PATIENT INFORMATION - Include Patient Demographics and Insurance Cards</b>			
Name:		DOB:	
<b>MEDICAL INFORMATION</b>			
ICD10:		Patient Height:	
Patient Weight (kg):		Allergies:	
*Weigh patient prior to each infusion			
<b>REQUIRED TESTING</b>			
Additional labs:			
<b>PREMEDICATIONS 30 minutes prior to starting</b>			
<input type="checkbox"/> Acetaminophen:	<input type="checkbox"/> 325mg PO X1	<input type="checkbox"/> 500mg PO X1	<input type="checkbox"/> 650mg PO X1 <input type="checkbox"/> 1000mg PO X1
<input type="checkbox"/> Diphenhydramine:	<input type="checkbox"/> 25mg IV X1	<input type="checkbox"/> 25mg PO X1	<input type="checkbox"/> 50mg IV X1 <input type="checkbox"/> 50mg PO X1
<input type="checkbox"/> Solumedrol:	<input type="checkbox"/> 40mg IV X1	<input type="checkbox"/> 100mg IV X1	<input type="checkbox"/> 125mg IV X1
<input type="checkbox"/> Antihistamine:	<input type="checkbox"/> Cetirizine 10mg PO X1 <input type="checkbox"/> Loratadine 10mg PO X1		
<input type="checkbox"/> Additional PRN:			
<b>TEZSPIRE ORDERS</b>			
<input type="checkbox"/> Tezspire	210mg subcutaneous once every 4 weeks X _____		
<b>POST INJECTION</b>			
<input type="checkbox"/> Discharge home			
Referring Provider Printed:		NPI:	
Referring Provider Signature:		Date:	
Referring Provider Phone:		Referring Provider Fax:	
DNG Provider Printed:			
DNG Provider Signature:		Date:	

*\*Credentials must be included*

**Injection Directions:**

- Remove from the refrigerator and bring to room temperature 60 minutes prior to injection
- If not using a pre-filled syringe:
  - Draw up Tezspire using a 3mL syringe and 18G needle, replace needle with 25G subcutaneous needle
- Inject in the front/middle of thigh, or upper arm

**Nursing Considerations:**

Must have a diagnosis of Severe Asthma