Tepezza

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Notes, Insurance Information, CAS Score, Recent Labs (Thyroid panel: Free T3, Free T4, TSH)

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ E05.00 ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

- ☑ Center will use Hypersensitivity protocol established by Infusion for Health and PI
- ☑ CAS Score: _____
- ☑ Thyroid Panel (Free T3, Free T4, TSH). List results:

_____

PRE-MEDICATION ORDERS

Pre-Medications not usually indicated.

- ☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
- ☐ Acetaminophen ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
- ☐ Methylprednisolone ☐ 40mg / ☐ 125mg IV
- ☐ Cetirizine ☐ 10mg PO
- ☐ Loratadine ☐ 10mg PO
- ☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS:

LABORATORY ORDERS

- ☑ Fingerstick Glucose ☑ at each dose
- ☐ CBC ☐ at each dose ☐ every _____
- ☐ Other: _____ ☐ every _____
- ☐ A1C (for diabetic patients) ☐ at each dose ☐ every _____
- ☐ Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

THERAPY ADMINISTRATION

- ☑ Tepezza Intravenous Infusion

Dose:
Infusion 1: 10mg/kg Total: _____
Infusions 2-8: 20mg/kg Total: _____
Frequency: Every 3 weeks, 8 infusions total

Dilute with 0.9% sodium chloride
If dose is <1799 mg: ☐ use 100 ml NaCl bag
If dose is >1800 mg: ☐ use 250ml NaCl bag

- ☑ Order is valid for 8 total infusions unless otherwise indicated. (Order will expire one year from date signed.)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

Provider Name (Print) | Provider Signature | Date

☐ ***Please check this box if you DO NOT authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.***