

Tepezza

teprotumumab



Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:

Patient Demographics; Insurance Information; All Clinical Documentation Supporting the Diagnosis Including Any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing

PATIENT INFORMATION

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

Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code (required): ☐ E05.00 ☐ H05.831 ☐ H05.832 ☐ H05.833 ☐ H05.839 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

- ☒ Deliver patient care in accordance with Infusion for Health clinical procedures and the medication's prescribing information (PI), including management of hypersensitivity reactions

PRE-MEDICATION ORDERS

Pre-Medications not usually indicated.

- ☐ diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650mg PO
☐ Other: _____
Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS:

LABORATORY ORDERS

- ☒ Fingerstick Glucose ☒ prior to each dose
☐ CMP ☐ at each dose ☐ every _____
☐ CBC ☐ at each dose ☐ every _____
☐ Other: _____
☐ 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
Infusions 2 through 8: 20mg/kg
Frequency: Every 3 weeks, 8 infusions total
☒ 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.