TEPEZZA® Referral Form





Fax Completed Form To:

PATIENT INFORMATION							
Patient Name:	Date of Birth:				Referral Date:		
Address:	T			City/State/Zip	State/Zip:		
Home Phone:	Cell Phone:			Work Phone:			
Secondary Contact: Height:			Weight:	leight: Male Female			
Patient Diagnosis & ICD	-10:						
Allergies:							
PROVIDER INFORMATION							
Physician Name: Lic.#:			DEA#:				
Practice Name:		NPI#:					
Address:	T.			City/State/Zip:			
Office Contact:	Phone:			Fax:			
Supervisory Physician (if applicable):							
PLEASE ATTACH							
Patient demographics & front/back copy of all insurance cards (prescription & medical) Recent office visit notes, history & physical, lab & pertinent procedure results Current medication list & list of prior medications tried and failed (with dates) History of IBD documentation Diabetic documentation Prior treatments for TED: steroids, surgeries, or other treatments CAS score Thyroid lab results Notes detailing if mild or moderate TED Documentation of lid retraction of 2 or more millimeters or Documentation of proptosis of 3 millimeters or more Letter of medical necessity if drug dosing or indication is outside of FDA guidelia a second course						es or if patient is receiving	
NURSING & LAB ORDERS							
Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.							
Flush Orders: NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - 10units/mLOR 10units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line Routine/Standing Lab Orders: (attach if needed) Blood glucose test every infusion(s). Pregnancy test prior to each infusion if childbearing age. Lab Orders: Lab Date & Frequency:							
PRESCRIPTION ORDERS							
Anaphylaxis Kit: (Check all that apply)	Epinephrine 0.3mg IM as needed Solu-cortef 250mg-500mg IV infusion as needed Diphenhydraminemg IV infusion as needed NS Hydration 500 ml IV infusion over 30 minutes as needed Other						
Pre-Medications: Acetaminophenmg POminutes prior to infusion Solu-Medrolmg IV infusionminutes prior to infusion (Check all that apply) Diphenhydraminemg POOR IV infusionminutes prior to infusion Other							
Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary							
PRODUCT	PRESCRIPTION INFORMATION					REFILLS	
Is this a first dose? Yes No If No, when was last dose given? When is patient due for next dose?							
TEPEZZA	INDUCTION: 10mg/kg IV infusion via gravityOR pump over 90 minutes for one time dose					NONE	
	MAINTENANCE: Maintenance: 20mg/kg IV infusion via gravity OR pump over 60 to 90 minutes every 3 weeks for 7 additional infusions					NONE	
	Administer the diluted solution intravenously over 90 minutes for the first two infusions. If well tolerated, the minimum time for subsequent infusions can be reduced to 60 minutes. If not well tolerated, the minimum time for subsequent infusions should remain at 90 minutes.						
OTHER							
By signing this form and utilizing our services, you are authorizing Amerita to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.							
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Prescriber's Signature Dispense as Written	Print Name	Date	Prescriber's Signa Substitution Pern		Print Name	Date	

Phone:





