TEPEZZA® Referral Form



Phone:

PATIENT INFORMATION						
Patient Name:	itient Name:		Date of Birth:		Referral Date:	
Address:		City/State/Zi				
Home Phone:		Cell Phone:		- · · · · · · · · · · · · · · · · · · ·	Work Phone:	
Secondary Contact:		Height: Weight:		E	🗆 Male 🗆 Female	
Patient Diagnosis & ICD-10:						
Allergies:						
PROVIDER INFORMATION						
Physician Name:		Lic.#: DEA #:		DEA #:		
Practice Name:		NPI#:				
Address:		City/State/Zip:				
Office Contact:		Phone: Fax:			X:	
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 guidelines or if patient is receiving a second course 			
NURSING & LAB ORDERS						
NORSING & 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 100units/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: Epinephrine 0.3mg IM as needed Solu-cortef 250mg-500mg IV infusion as needed Solu-Medrol 60mg - 125mg IV infusion as needed (Check all that apply) Diphenhydramine mg IV infusion as needed NS Hydration 500 ml IV infusion over 30 minutes as needed Other						
Pre-Medications: Acetaminophenmg P0minutes prior to infusion Solu-Medrolmg IV infusionminutes prior to infusion (Check all that apply) Diphenhydraminemg P0 OR 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		PRESCRIPT	ION INFORMATIO	N		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 🖾 gravityOR 🖾 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.					
D 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.						

Prescriber's Signature **Dispense as Written**

Print Name

Date

Prescriber's Signature **Substitution Permitted** Print Name

Date





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