

# TEPEZZA® Referral Form

Fax completed form to: 833-908-1122



PATIENT INFORMATION			
Patient Name:	Date of Birth:	Referral Date:	
Address:		City/State/Zip:	
Home Phone:	Cell Phone:	Work Phone:	
Secondary Contact:	Height:	Weight:	Male Female
Patient Diagnosis & ICD-10:			
Allergies:			
PROVIDER INFORMATION			
Physician Name:	Lic.#:	DEA #:	
Practice Name:		NPI#:	
Address:		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 guidelines or if patient is receiving a second course	
NURSING & LAB ORDERS			
<b>Nurse Orders:</b> Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders. <b>Flush Orders:</b> NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - 10units/mL ---OR--- 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line <b>Routine/Standing Lab Orders:</b> (attach if needed) Blood glucose test every _____ infusion(s). Pregnancy test prior to each infusion if childbearing age. <b>Lab Orders:</b> <b>Lab Date &amp; Frequency:</b>			
PRESCRIPTION ORDERS			
<b>Anaphylaxis Kit:</b> 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			
<b>Pre-Medications:</b> Acetaminophen _____ mg PO _____ minutes prior to infusion Solu-Medrol _____ mg IV infusion _____ minutes prior to infusion (Check all that apply) Diphenhydramine _____ mg PO ---OR--- IV infusion _____ minutes prior to infusion Other			
<b>Supply Orders:</b> 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	<b>INDUCTION:</b> 10mg/kg IV infusion via gravity ---OR--- pump over 90 minutes for one time dose		NONE
	<b>MAINTENANCE:</b> Maintenance: 20mg/kg IV infusion via gravity ---OR--- pump over 60 to 90 minutes every 3 weeks for 7 additional infusions <input checked="" type="checkbox"/> 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.		NONE
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 \_\_\_\_\_

