Thyroid Eye Disease Referral Form

Amerita
YOUR INFUSION ADVOCATE

Fax Completed Form To: **Phone:**

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

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/mL ***---OR---*** ☐ 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: (Check all that apply)
☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV infusion as needed ☐ Solu-Medrol 60mg - 125mg IV infusion as needed
☐ Diphenhydramine _____ mg IV infusion as needed ☐ NS Hydration 500 ml IV infusion over 30 minutes as needed ☐ Other

Pre-Medications: (Check all that apply)
☐ Acetaminophen _____ mg PO _____ minutes prior to infusion ☐ Solu-Medrol _____ mg IV infusion _____ minutes prior to infusion
☐ Diphenhydramine _____ mg ☐ PO ***---OR---*** ☐ IV infusion _____ minutes 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 ☐ gravity ***---OR---*** ☐ 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 ☐ 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. *The FDA-approved indication for TEPEZZA was updated to specify its use for the treatment of Thyroid Eye Disease regardless of disease activity or duration*	NONE
☐ LUMVOA	☐ 10mg/kg IV infusion via ☐ gravity ***---OR---*** ☐ pump over 45 minutes every 3 weeks x 5 doses. * If well tolerated, subsequent infusions can be administered over a minimum of 30 minutes	NONE
☐ OTHER		_____

By signing this form and utilizing our services, you are authorizing Amerita to assist with prior authorization requests acting as your pharmacy provider in dealing with medical and prescription insurance companies.

Prescriber's Signature **Print Name** **Date**
Dispense as Written

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

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THIS FORM IS NOT VALID FOR USE IN THE STATE OF ARIZONA.

ACHC ACCREDITED
PCAB ACCREDITED Compounding Pharmacy