Tepezza® Referral Form

IVCareOptions

PHONE: 1-800-277-7302 FAX: 1-866-374-6663

Demographics Information: Today's Date _____

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: GA Zip: _____

Phone #: _____ ☐ Cell Alternate Phone #: _____ ☐ Cell

Height: _____ in/ft Weight: _____ lbs/kg Date weight recorded: _____ Last 4 of SSN#_____

Allergies: _____ ☐ **NKDA**

Diagnosis Information: ☐ E05.00 Thyrotoxicosis with diffuse goiter without crisis/storm ☐ E05.01 Thyrotoxicosis with diffuse goiter with thyrotoxic crisis/storm ☐ E05.10 Thyrotoxicosis with toxic single thyroid nodule without thyrotoxic crisis/storm ☐ E05.11 Thyrotoxicosis with toxic single thyroid nodule with thyrotoxic crisis/storm ☐ E05.20 Thyrotoxicosis with multinodular goiter without thyrotoxic crisis/storm ☐ Thyrotoxicosis with multinodular goiter with thyrotoxic crisis/storm ☐ Thyrotoxicosis for ectopic thyroid tissue without crisis/storm.

Date Infusion to Begin: _____

Previous Infusion Reaction: ☐ YES ☐ NO

List Reactions: _____

Is this a first infusion? ☐ YES ☐ NO

Date of Last Infusion: _____

List of Failed Therapies: _____

Assessment Questions: *Please Provide Appropriate Documentation*

Diabetes? ☐ Yes ☐ No HTN? ☐ Yes ☐ No Cardiac History? ☐ Yes ☐ No Difficulty Breathing? ☐ Yes ☐ No

Requires Oxygen? ☐ Yes ☐ No Confusion /Disorientation? ☐ Yes ☐ No Neuro History? ☐ Yes ☐ No

Date of Negative TB test: _____ FAP stage _____ Baseline Polyneuropathy Disability score _____

Tepezza® (teprotumuminab) J3241

☐ **Initial dose:** 10mg/kg IV x 1 dose followed by 20 mg/kg IV every 21 days for _____ months.

☐ **Maintenance dose:** 20mg/kg IV every 21 days for _____ months.

Pre-Medications: Patient to provide and take 60 minutes prior to infusion

☐ Acetaminophen 500 mg PO x1

☐ Benadryl 50 mg PO x 1 dose

☐ Other Pre-medication: _____

Access: ☐ **PIV** ☐ **PORT** ☐ **PICC** **Route:** ☐ **IV**

Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency

PIV – NS 5mL: Qty 3

PORT – NS 10mL: Qty 3, Heparin 5mL 100units/mL x 1 per infusion

PICC – NS 10mL: Qty 3, Heparin 5mL 10units/mL x 1 per infusion

Supplies: (please strike through if not required)

Administration Supplies (A4222) – 1 per infusion

Catheter Care Supplies (A4221) – 1 per week

Infusion Pump (E0781)

Nursing services to administer

For insurance compliance, the prescribing physician or PA must sign, no stamps or nurse/NP signatures

Physician/PA signature: _____

NPI # _____ Phone Number _____

Office Address: _____ City: _____ St ____Zip: _____

Printed Name: _____ Contact Name: _____

Please fax this form to our Intake Department along with a copy of Patient's Insurance Card, Demographic information, H & P, Office Visit notes - including supporting documentation for failed therapies, and Up to Date Medication List.