# 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: ___________________________

*Please Provide Appropriate Documentation and complete: Clinical Activity Score (CAS) Form*

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.**