

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: <u>GA</u> Zip: _____
Phone #: _____ <input type="checkbox"/> Cell	Alternate Phone #: _____ <input type="checkbox"/> Cell
Height: _____ in/ft Weight: _____ lbs/kg	Date weight recorded: _____ Last 4 of SSN# _____
Allergies: _____	<input type="checkbox"/> 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: _____	Is this a first infusion? <input type="checkbox"/> YES <input type="checkbox"/> NO
Previous Infusion Reaction: <input type="checkbox"/> YES <input type="checkbox"/> NO	Date of Last Infusion: _____
List Reactions: _____	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: <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> PICC Route: <input type="checkbox"/> IV	Supplies: (please strike through if not required)
Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency	Administration Supplies (A4222) – 1 per infusion
PIV – NS 5mL: Qty 10	Catheter Care Supplies (A4221) – 1 per week
PORT – NS 10mL: Qty 10, Heparin 5mL 100units/mL x 1 per infusion	Infusion Pump (E0781)
PICC – NS 10mL: Qty 10, Heparin 5mL 10units/mL x 1 per infusion	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 GA 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.

05/21 TSP