Tepezza® Referral Form

PHONE: 1-800-277-7302 FAX: 1-866-374-6663 Email: intake@healthcoga.com □ ***Initial Order*** □ ***Reorder***

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

CAS score: _____ Free T3 and Free T4 _____

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 325 mg PO x1 □Acetaminophen 650 mg PO x1

□ Benadryl 50mg PO X1 □ Benadryl 25 mg Po x1

□ 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 medications

Administer the anaphylaxis protocol for adverse reactions

Provider signature: _____

NPI # _____ Phone _____ Fax _____

Office Address: _____ City: _____ St ____Zip: _____

Printed MD Name: _____ Contact Name: _____

□ Demographic information □ Patient Ins. Card □ H & P □ Office notes □ Failed therapies in documentation

□ Up to date medication list

9/23 TSP