

Physician Infusions Tepezza™ Referral Form

Patient Information

Patient Name: _____ DOB: _____ Height: _____ Weight: _____
Address: _____ Phone: _____ Email: _____

Insurance Information (Include a copy of the front and back of patient's insurance card)

Primary: Policy #: _____ Group #: _____ Ins Phone: _____
Secondary: Policy #: _____ Group #: _____ Ins Phone: _____

Referring Provider Office Information

Provider Name: _____ NPI: _____ Office Name: _____
Office Address: _____
Office Contact: _____ Phone: _____ Fax: _____ Email: _____

Pre-medications

_____ mg Acetaminophen PO _____ mg Diphenhydramine PO
 _____ mg Cetirizine PO _____ mg Diphenhydramine IV
 _____ Other IV/PO _____ mg Solumedrol IV

Physician Infusions to order pre-medications per Physician Infusions protocols/procedures

Required Labs

CBC CMP TB TSH Free T3 Free T4

Laboratory Frequency: _____

-- OR --

Physician Infusions to order baseline labs/glucose screenings and calculate CAS score

Prescription

Diagnosis Code: _____ Diagnosis Description: _____

Allergies: _____

Medication: Teprotumumab-trbw Route: IV First Infusion? Y/N Last Infusion Date (If applicable): _____

Frequency: Every 3 weeks Total Infusions: 8 How many infusions has the patient had?: ____ out of 8

Administration: Dilute with 0.9% Sodium Chloride. <1800 mg in 100 mL bag. >1800 mg in 250 mL bag.

First infusion (90 minutes): 10 mg/kg

Second infusion (90 minutes): 20 mg/kg

Infusion 3-8 (60 minutes if tolerated): 20 mg/kg

Is the patient required to stay for a 30-minute observation period? Y/N

Provide nursing care per Physician Infusions policies and procedures, including but not limited to post-infusion observation and management of adverse reactions.

Special Instructions

Physician Infusions will choose the product/biosimilar medication based on payor requirements, availability, and clinical indication.

Please send completed referral form, office notes, labs/imaging results (including TB result and date) to Physician Infusions fax (512) 354-4938.

Prescriber Signature: _____ Prescriber Printed Name: _____ Date: _____