

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

☐ Physician Infusions to order pre-medications per standard infusion protocols/procedures

-- OR --

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

Required Labs

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

-- OR --

☐ CBC, CMP, Quantiferon TB, TSH, Free T3, Free T4

Laboratory Frequency: _____

Prescription

Diagnosis Code: _____ Diagnosis Description: _____
Allergies: _____
Medication: Tepezza 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 if applicable) to Physician Infusions fax (512) 354-4938.

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