

TEPEZZA

(teprotumumab-trbw)

FLEXCARE
INFUSION CENTERS**PATIENT DEMOGRAPHICS**

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card • History & Physical • Patient Demographics • Medication List • Recent Thyroid Panel • Neg Pregnancy Test
- CAS Score: _____ • Patient Ethnicity (can affect proptosis requirements): _____
- Endocrinologist's Name: _____ • Ophthalmologist's Name: _____

PRIMARY DIAGNOSIS

- | | |
|---|---|
| ☐ E05.00 Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm | ☐ H05.833 Thyroid orbitopathy, bilateral |
| ☐ H05.831 Thyroid orbitopathy, right orbit | ☐ H05.839 Thyroid orbitopathy, unspecified orbit |
| ☐ H05.832 Thyroid orbitopathy, left orbit | ☐ Other: _____ |

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

*HgbA1c will be drawn at baseline and every 3 months while on therapy, per FlexCare protocol (no cost to payor or patient).

*hCG will be performed at each visit for patients who may become pregnant

☒ Per infusion clinic protocol: No recommended standard pre-meds for Tepezza☐ Provider Prescribed: _____**PRIMARY MEDICATION ORDER**

**Patients with pre-existing diabetes should be under appropriate glycemic control before receiving Tepezza.

☐ Tepezza 10mg/kg (_____ mg) IV once followed by 20mg/kg (_____ mg) IV every 3 weeks for seven additional treatments☐ Other: _____First Dose: ☐ Y ☐ N ☒ Refill x12 months unless otherwise noted: _____**LINE USE/CARE ORDERS**☒ Start PIV/ACCESS CVC ☒ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)☐ Other Flush Orders: Please fax other line care orders if checking this box**ADVERSE REACTION & ANAPHYLAXIS ORDERS**☒ Administer acute infusion reaction and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)☐ Other: Please fax other reaction orders if checking this**PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION**

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI AND License:	☐ Email:

Provider Signature _____

Date _____

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals