HERITAGE BIOLOGICS

Teprotumumab-trbw (Tepezza) Patient Referral Form

Admissions Fax # 844-878-6917

Admissions Phone # 855-WE-R-RARE (855-937-7273)

Patient Demographics Information

Patient Name		SSN#	DOB
Patient Address			
Primary Phone	Cellular Phone	Work Phone	
Emergency Contact Name, Relationship		Emergency Contact Phone Number	

Additional Documentation Needed

- ☸ Copy of insurance cards
- ☸ History and Physical
- ☸ Patient face sheet w/demographics

Patient Insurance Information

Insurance Plan #1			Insurance Plan #2		
Plan Address			Plan Address		
Plan Phone & Fax Numbers			Plan Phone & Fax Numbers		
Subscriber Name	DOB		Subscriber Name	DOB	
Policy Number	Group ID		Policy Number	Group ID	

Patient Clinical Information

Gender ☐M ☐F	Height (inches)	Weight (lbs.)	Allergies (food/drug)

Statement of Medical Necessity / Primary Diagnosis

ICD10: Description of diagnosis:

Medication Information / Prescription and Orders

Medication:

Tepezza 500 mg

Directions:

Infuse IV per manufacturer guidelines **OR** over _____ hours.

Prior to infusion, reconstitute each Tepezza 500 mg vial with 10 mL of Sterile Water for Injection and mix in a NaCl 0.9% bag for total 100 mL for doses <1800 mg or 250 mL for doses ≥1800 mg

Initial dose

☐ _____ mg (10 mg/kg) IV once

#1 dose, 21-day supply, no refill

Subsequent doses 2-8

☐ _____ mg (20 mg/kg) IV every 3 weeks

#1 dose, 21 day supply, refill x 6

*If subsequent treatment cycles only

Date of last infusion:

Next dose due:

Line Access

☐ RN to start peripheral IV or use existing CVC. RN to administer catheter flushing 2-10 mL IV as needed for infusion and line maintenance.

☐ 0.9% Sodium Chloride ☐ Heparin 10 units/ml ☐ Heparin 100 units/ml ☐ 0.9% Sodium Chloride Sterile (port)

Adverse Reaction Orders

*** If infusion reaction occurs pause infusion for 10 minutes, resume infusion at previously tolerated rate and use appropriate medical management. If reaction continues, stop infusion and notify physician.**

Prescriber Information

Physician Name		Office Contact	
Practice Address		Practice Phone	
NPI#	License #	DEA#	
Physician Signature Required - Substitution Permitted	Date	Physician Signature Required - Dispense as Written	Date