

**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
- Patient face sheet w/demographics
- History and Physical

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)
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Statement of Medical Necessity / Primary Diagnosis

ICD10:	Description of diagnosis:
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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
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Initial dose ☐ _____ mg (10 mg/kg) IV once #1 dose, 21-day supply, no refill	*If subsequent treatment cycles only Date of last infusion:
Subsequent doses 2-8 ☐ _____ mg (20 mg/kg) IV every 3 weeks #1 dose, 21 day supply, refill x 6	Next dose due:

Line Access RN to start peripheral IV or use existing CVAD. RN to administer catheter flushing and medications per orders below. ☐ Sodium Chloride 0.9% 10 mL Flush: Flush with 2-10 mL sodium chloride 0.9% IV before and after medication administration or every 24 hours while IV access in place. ☐ Sodium Chloride 0.9% 10 mL STERILE Flush: Flush with 5-10 mL STERILE sodium chloride 0.9% IV as needed for port access. ☐ Heparin Lock 100U/mL 5 mL Flush: Lock with 5 mL heparin 100U/mL after each use or daily while port accessed.	Line Type: ☐ PIV ☐ Port/CVAD	Quantity/Refills Dispense: Quantity #QS + PRN refills unless otherwise noted ☐ Other
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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