

***Patient Insurance & ID (front and back) are needed**

TEPEZZA (teprotumumab-trbw)

New Prescription/Referral
Prescription Refill

Of Refills:

Rx:

Patient Name:

Patient Weight:

kg

DOB:

Tepezza:
(teprotumumab-trbw)

Initial Dose: Infuse 10 mg/kg at week 0 (1 Dose)

Maintenance Dose: Infuse 20 mg/kg every 3 weeks for 7 additional infusions (7 Doses)

Others: _____

Pre-Medication:

ANA Kit Protocol:

Solumedrol 125mg IVP

Tylenol _____ mg PO

Benadryl _____ mg PO

OK to use

Solu-Cortef 100mg IVP

650 mg 975 mg

25 mg IV

Others: _____

50 mg PO

Dx:

Diagnosis: Thyrotoxicosis w diffuse goiter w/o thyrotoxic crisis or storm (ICD-10: E05.00)

Other: _____

ICD-10: _____

Physician Signature

NPI #:

DATE:(Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name:

Clinic:

Phone:

Fax:

Email:

Other:

Office Mailing Address:

**Please include
the following.**

Patient demographics

Insurance attached

Diagnosis(supporting)

History & Physical

Lab Results

Clinical progress notes

Medication list

Other Test Results

Clinical Activity Score (CAS)

Thyroid Panel with TSH

HbA1C (if available)

Free T3 and Free T4

We can do patient teaching for IV/IM/SQ injections if needed. One time or multiple visits. If insurance allows we can also administer SQ/IM shot.