Tepezza

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS

smartchoiceinfusion.com
Ph: 818-659-8182
Fax: 818-659-8990

Date: _____ Treatment Location: _____

***Please fax a copy of the following patient information:** Most Recent Office Visit Note, Insurance Information, Medication List, CAS Score, Recent labs (Thyroid panel to include Free T3, Free T4, TSH; CMP/BMP; A1C for diabetic patients
Auditory screening is recommended for all patients prior to first Tepezza infusion.

PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: ☐ Thyroid Eye Disease (TED) ICD 10-E05.00
☐ Graves' orbitopathy ICD 10-H05.20

Other Dx/ICD10: _____

PROVIDER INFORMATION

Prescriber's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

MEDICATION DOSAGE:

Date of Last Infusion: Number of Completed Infusions:

Patient Weight (in kg): _____ **Route**: ☑ IV

Dose: Infusion 1: _____ mg (10 mg /kg) Infusion 2: _____ mg (20 mg /kg)

Frequency: Q3 weeks, 8 infusions total

If dose is < 1799 mg use 100 ml NaCl bag , if dose is >1800 use 250ml NaCl bag

Start Date of Infusion: _____