

TEPEZZA

Please include the following to expedite the order:
Patient Demographics, Insurance Information, Recent Labs

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ DOB: _____ Gender: ☐ M ☐ F ☐ Other _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

PRESCRIBER

Name: _____ DEA: _____ NPI: _____ State License: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

CLINICAL

Diagnosis: ☐ E05.00 (Thyrotoxicosis w diffuse goiter w/o thyrotoxic crisis)

Allergies: _____ Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in

Diabetes: ☐ Yes ☐ No If yes, managed: ☐ Yes ☐ No *Glucose will be checked via
fingerstick before every infusion*

TREATMENT

TEPEZZA (teprotumumab)

Route: Intravenous Infusion

Dose: ☐ 10mg/kg ☐ 20mg/kg

Frequency:

☐ Every 3 weeks, 8 infusions in total

Premedication Protocol: *(Not Usually Indicated)*

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ Other: _____

Sig: _____

☒ Center will use anaphylactic and hypersensitivity
protocol established by Restore Health

Special Instructions: _____

Quantity: _____ Refills: _____

Provider Signature: _____

Date: _____

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