RESTORE HEALTH
INFUSION AND WELLNESS

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

Quantity: _____ Refills: _____

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: _____

Provider Signature: _____ Date: _____