

**PATIENT DEMOGRAPHICS**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City/ST/Zip: \_\_\_\_\_  
Allergies: \_\_\_\_\_  NKDA Weight: \_\_\_\_\_  lbs  kg Height: \_\_\_\_\_  in  cm  
**Patient Status:**  New to Therapy  Dose or Frequency Change  Order Renewal

**INSURANCE INFORMATION: Please attach copy of insurance card (front and back).**

**DIAGNOSIS\***

**\*ICD 10 Code Required**  Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm, **ICD10: E05.00**  
 Other: \_\_\_\_\_ ICD10: \_\_\_\_\_

**INFUSION ORDERS**

MEDICATION	DOSE	DIRECTIONS/DURATION
Tepezza® (teprotumumab)	<input type="checkbox"/> <b>Initial Dose:</b> _____ mg (10 mg/kg) <input type="checkbox"/> <b>Subsequent Doses:</b> _____ mg (20 mg/kg)	<input type="checkbox"/> <b>Initial:</b> Infuse IV over 90 minutes x 1 dose. <input type="checkbox"/> <b>Subsequent:</b> Infuse IV over 90 minutes every 3 weeks x _____ doses. (maximum 7) *If first 2 infusions are well tolerated, may reduce subsequent infusion times to over 60 minutes.

**Is patient currently receiving therapy above from another facility?** If yes, Facility Name: \_\_\_\_\_  
 Yes  No Date of last treatment: \_\_\_\_\_ Date of next treatment: \_\_\_\_\_

**PRE-MEDICATION ORDERS**

No premeds ordered at this time  
 Acetaminophen 650mg PO  Diphenhydramine 25mg PO  
 Methylprednisolone 40mg IVP -OR-  Hydrocortisone 100mg IVP  
 Other: \_\_\_\_\_

**LAB ORDERS**

**Labs to be drawn by:**  Infusion Center  Referring Physician  
 No labs ordered at this time  
 Blood glucose q \_\_\_\_\_  CBC with diff/platelet q \_\_\_\_\_  
 CMP q \_\_\_\_\_  Other: \_\_\_\_\_

**REFERRING PHYSICIAN INFORMATION**

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Physician Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ City/ST/Zip: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Email Where Follow Up Documentation Should Be Sent: \_\_\_\_\_

**REQUIRED CLINICAL DOCUMENTATION**

**Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.**

**See Attached Medical Records**  
 Yes  No Is active Thyroid Eye Disease (TED) confirmed with a baseline Clinical Activity Score (CAS) of  $\geq 4$  in the more severely affected eye?  
 Yes  No Does the patient present with at least ONE of the following features of moderate-to-severe TED?  
*If yes, please select all that apply:*  
 Lid retraction  $\geq 2$ mm  
 Moderate or severe soft tissue involvement  
 Exophthalmos  $\geq 3$ mm above normal for race and gender  
 Intermittent or constant diplopia  
 Other: \_\_\_\_\_  
 Yes  No Is patient euthyroid or currently receiving treatment to correct mild hypo- or hyperthyroidism (e.g., free T4 and free T3 levels are  $< 50\%$  above or below normal limits)?

**LAB AND TEST RESULTS (required)**

Thyroid Eye Disease (TED) Clinical Activity Score (CAS) report  
 Thyroid functions tests (free thyroxine [T4], free triiodothyronine [T3])  
 Other: \_\_\_\_\_

**PRIOR FAILED THERAPIES**

Medication Failed: \_\_\_\_\_ Dates of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_  
Medication Failed: \_\_\_\_\_ Dates of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_  
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Medication Failed: \_\_\_\_\_ Dates of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_