Tepezza® (Teprotumumab)

Referring Physician Order Form

Please fax completed referral form & all required documents to 770-618-9617

CPS | INFUSION

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)	☐ **Initial Dose:** _____ mg (10 mg/kg) ☐ **Subsequent Doses:** _____ mg (20 mg/kg)	☐ **Initial:** Infuse IV over 90 minutes x 1 dose. ☐ **Subsequent:** 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?

☐ Yes ☐ No

If yes, Facility Name: _____

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 ≥ 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 ≥ 2mm
- ☐ Moderate or severe soft tissue involvement
- ☐ Exophthalmos ≥ 3mm 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: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____