InfuCare Rx

Tepezza®
Referral Form

of Pages Faxed: ___________
Fax Referral To: 877-277-9155
Phone: 877-828-3940

Date Required: ______________ Ship To: ☐ Home ☐ Office ☐ Other: ______________

PATIENT INFORMATION

Patient Name: ______________
Address: ______________
City, State, Zip: ______________
Home Phone: ______________
Cell Phone: ______________
Alternate Phone: ______________
Date of Birth: ______________

PRESCRIBER INFORMATION

Prescriber Name: ______________
Address: ______________
City, State, Zip: ______________
Phone: ______________
Fax: ______________
DEA #: ______________ NPI #: ______________
Contact Person: ______________

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: ______________ ID: ______________ Group: ______________
Secondary Insurance: ______________ ID: ______________ Group: ______________
Prescription Card: ______________ ID: ______________ BIN: ______________ PCN: ______________

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS

☐ E05.00 Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm (hyperthyroidism)
☐ Other: ______________

MEDICAL HISTORY

Patient Weight: ________ ☐ kg ☐ lbs Height: ________ ☐ cm ☐ in
Allergies: ______________
Line Access: ☐ Peripheral ☐ Port
Delivery Method: ☐ Infusion Pump ☐ Other: ______________
Therapy Start Date: ______________ Therapy End Date: ______________
Nursing Coordination:
☐ Pharmacy to coordinate home health nursing visit as necessary: ☐ Yes ☐ No
☐ Home health nursing coordination not necessary. Reason:
☐ MD office to administer to patient
☐ Home health nursing already coordinated
Lab Orders: ______________

PRESCRIPTION INFORMATION

Tepezza® (Teprotumumab-trbw) Prescription:	**Quantity:**	**Refills:**
Initiate services beginning with Dose No. ______ as indicated below:		
☐ Dose 1: Infuse 10 mg/kg IV over 90 minutes, then 3 weeks later...		
☐ Dose 2: Infuse 20 mg/kg IV over 90 minutes, then 3 weeks later...		
☐ Dose 3 through 8: Infuse 20 mg/kg IV over 60 to 90 minutes (as tolerated by patient) every 3 weeks x 6 doses.		

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol

Peripheral:
☐ NaCl 0.9% 5mL
☐ NaCl 0.9% 10mL

Implanted Port:
☐ NaCl 0.9% 5 to 10mL pre-/post-use and 10 to 20mL pre-/post-lab draw
☐ Heparin (100 unit/mL) 3 to 5 mL post-use
☐ For maintenance, heparin (100 unit/mL) 3 to 5mL every 24 hr if accessed or weekly to monthly if not accessed

☐ Other: ______________

Premedications & Other Medications

☐ Infusion supplies as per protocol
☐ Anaphylaxis Kit orders as per protocol
☐ Acetaminophen 650 mg PO prior to infusion
☐ Diphenhydramine 25 mg PO

ADDITIONAL COMMENTS:

Prescriber Signature: ______________ **Date:** ______________

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