

Richmond
1110 Forest Ave, Suite 203
Richmond, VA 23226



Prince George
2025 Waterside Rd, Suite 100B
Prince George, VA 23875

Physician Order - Tepezza (teprotumumab-trbw)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:

REFERRAL STATUS	
<input type="checkbox"/> New Referral	<input type="checkbox"/> Dose/Frequency Change <input type="checkbox"/> Order Renewal

Location Preference (optional)	
<input type="checkbox"/> Richmond	<input type="checkbox"/> Prince George

* * If the patient has a central line - we need official placement report, diagnostic imaging to confirm tip placement and date of last access * *

DIAGNOSIS AND ICD-10 CODE	
<input type="checkbox"/> Thyrotoxicosis w/ diffuse goiter w/o thyrotoxic crisis or storm (hyperthyroidism)	E05.00
<input type="checkbox"/> Other: _____	ICD10 _____

REQUIRED DOCUMENTATION (must include)	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress Notes
<input type="checkbox"/> Patient Demographics AND Insurance Information	<input type="checkbox"/> Labs and Tests Supporting Primary Dx
<input type="checkbox"/> Thyroid Function Test (T4 and T3 levels)	<input type="checkbox"/> Thyroid Eye Disease Clinical Activity Score (CAS)
<input type="checkbox"/> Patient currently receiving same therapy at _____	Last dose: _____

List Tried & Failed Therapies, including duration of treatment

1)
2)
3)

MEDICATION ORDERS**	
Initial Dosing	<input type="checkbox"/> Tepezza 10mg/kg infuse IV over 90 minutes x 1 dose
Maintenance Dosing	<input type="checkbox"/> Tepezza 20mg/kg infuse IV over 90 minutes every 3 weeks x 7 doses
*if first 2 infusions are well tolerated, may reduce subsequent infusions time to 60 minutes	
Patient Weight = _____ kg	Patient Height = ____ ft ____ in
Duration: <input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> doses _____	

**Patient weight is required for all weight based therapies - please indicate weight in kilograms.

OPTIONAL PREMEDICATIONS and LAB ORDERS	
<input type="checkbox"/> Acetaminophen 650mg PO prior to infusion	
<input type="checkbox"/> Diphenhydramine 25mg PO or IV (per patient preference) prior to infusion	
<input type="checkbox"/> Methylprednisolone 40mg slow IVP prior to infusion	
<input type="checkbox"/> Other PreMed or Lab Order with frequency:	

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION			
Prescriber Name:	NPI:	Contact:	
Phone:	Fax:	Email:	
Prescriber Signature:	Date:		

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com

Fax completed form and ALL required documentation to 804-554-5848

All information contained in this form is strictly confidential and will become part of the patient's record.