INTRAMED Plus
infusion services

TEPEZZA®

INFUSION & MEDICAL CENTER

1. Patient Name ______________________ **DOB** __________ **Patient Phone/Cell #** ______________

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ Thyroid Eye Disease (TED) ICD-10 Code: E05.00 ______

_____ Other: ______________________________ ICD-10 Code: ___________

Allergies: ____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
  - Recent Lab Results including Baseline Glucose or other measures or glycemic control
- Negative pregnancy test results within 48 hrs prior to Tepezza infusion

Patient Weight: __________ lbs.

Height: __________ in.

TEPEZZA® (Teprotumumab-trbw)

4. Drug Order:

❑ First Infusion
Administer Tepezza 10 mg/kg IV (________ mg) over 90 minutes

❑ Subsequent Infusions # Refills ______(Maximum of 7 Infusions)
Administer Tepezza 20 mg/kg IV (________ mg) over 60 - 90 minutes every three weeks

Pre-Medication Orders: ____
No pre-medications are recommended based on manufacturer guidelines.

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus
to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: ___________________________ / ___________________________ Date: ____________

Dispense as written Substitution permitted

Printed Physician's Name: ____________________________________ Contact Phone #: ____________________

FAX ALL INFORMATION CENTRAL FAX **803.999.1754** ALTERNATE FAX 803.999.1887	<u>INFUSION CENTER LOCATIONS</u> COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 800.767.6337

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