

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	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 803.999.1760
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