



MEDICATION ORDERS

TEPEZZA (TEPROTUMUMAB-TRBW)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

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

INFUSION OFFICE PREFERENCE (Optional)		
Preferred Location:	<input type="checkbox"/> Montgomery	<input type="checkbox"/> Prattville

DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Thyroid Eye Disease	ICD 10 Code: E05.00
<input type="checkbox"/> Other:	ICD10 Code:

REQUIRED DOCUMENTATION/TESTING	
<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 diagnosis

MEDICATION ORDERS	
<input type="checkbox"/> Initial IV Dosing	<input type="checkbox"/> Tepezza 10mg/kg IV once, initial dose
<input type="checkbox"/> Maintenance Dosing (will start 3 weeks after initial dose, when applicable)	<input type="checkbox"/> Tepezza 20mg/kg IV every 3 weeks x 7 doses
<input type="checkbox"/> Other (please include dose, route, frequency, and number of refills)	<input type="checkbox"/> Tepezza _____

NOTE: First and second doses will be administered over 90 minutes and, if tolerated, subsequent doses will be administered over 60 minutes.

PROVIDER INFORMATION			
Office Contact Name:			
Prescribing Providers Name:		Provider NPI:	
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
Physician Signature:	Date:		

Contact us with questions at: Montgomery (334) 273-7000 or Prattville (334) 351-1000
Fax completed form and all documentation to Montgomery (334) 260-2011 or Prattville (334) 358-1207