

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____
 ADDRESS: _____ CITY, STATE, ZIP: _____
 DATE OF BIRTH: _____ EMAIL: _____
 ALLERGIES: SEE LIST NKDA WEIGHT: LB OR KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. H & P 3. Patient Demographics 4. Med List 5. Recent Thyroid Panel 6. Neg Pregnancy Test
 7. CAS Score: _____
 8. Patient Ethnicity (can affect proptosis requirements): _____
 9. Endocrinologist's Name: _____
 10. Ophthalmologist's Name: _____

PRIMARY DIAGNOSIS

E05.00 Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

Per infusion clinic protocol: No recommended standard pre-meds for Tepezza
 Provider Prescribed: _____

PRIMARY MEDICATION ORDER

****Patients with pre-existing diabetes should be under appropriate glycemic control before receiving Tepezza.**

Tepezza 10 mg/kg (_____ mg) IV followed by 20 mg/kg (_____ mg) IV every 3 weeks for seven additional treatments
 Other _____ FIRST DOSE?: Yes No Refill x12 months unless otherwise noted.

LINE USE/CARE ORDERS

Start PIV/ACCESS CVC Flush device per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)
 Other Flush Orders: (Please send other line care orders if checking this box)

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)
 Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____
 OFFICE CONTACT: _____ FAX: _____
 ADDRESS: _____
 CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

X

PROVIDER SIGNATURE _____ DATE _____