Teprotumumab-trbw (Tepezza®) Referral Form

Please complete the following and fax with clinical documentation to:
FAX: 844.276.4128
EMAIL BOX: tedtherapy@soleohealth.com
PHONE: 844.968.4747

Referral Process

1. PATIENT INFORMATION (*indicates a required field)	2. PHYSICIAN INFORMATION (*indicates a required field)
Name*: ____________________	Physician's name*: ____________________
Address*: ____________________	License #: __________ NPI #*: __________
City*: __________ State*: _____ Zip*: _____	DEA #: __________ Email*: __________
Home Phone: __________ Mobile Phone*: __________	Address*: ____________________
Email*: ____________________ Primary language*: ____________________	City*: ____________________ State*: _____ Zip*: __________
DOB*: __________ Social Security #*: __________	Office Contact: ____________________
Gender*: ☐ M ☐ F Height: _____ Weight*: _____	Phone*: __________ Fax*: __________ Specialty*: __________

Allergies*: ____________________ NKA*: ☐
Alternate contact name: ____________________ Alternate contact phone: ____________________
☐ Yes ☐ No* Consent to leave voice message at the patient and/or alternate contact phone

3. DIAGNOSIS (*indicates a required field) Year of diagnosis: __________
☐ *(E05.00) Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm (hyperthyroidism)
☐ Yes ☐ No* Does the patient have documented Thyroid Eye Disease? ***If not, the patient is not a candidate for Tepezza.***
☐ Other diagnoses: ____________________

4. INSURANCE INFORMATION
Please submit copies of the front and back of primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION Anticipated Start Date: ____________________

Prescription*: Teprotumumab-trbw (Tepezza®) 500 mg vial for intravenous use
Prior to administration, dilute doses <1800mg in 100 mLs 0.9% Sodium Chloride and
doses ≥ 1800mg in 250 mLs 0.9% Sodium Chloride.
Duration: 1 infusion every 3 weeks for a total of 8 infusions. Administer the first two infusions over 90 minutes. If well tolerated, subsequent infusions may be reduced to 60 minutes.
Dose: Week 0: _____ mg (10mg/kg) Week 3: _____ mg (20mg/kg)
21 day supply; 1 prescription; no refill 21 day supply: 1 prescription; 6 refills; q3wks

Premedication orders: ____________________
Additional orders: _____
Access: ☐ Peripheral Other: _____

FLUSH ORDERS
PIV/midline/PICC: Flush before, after each infusion, and as needed with 3-20 ml NS, followed by Heparin 2-5 ml if indicated
☐ Heparin 10 unit/ml ☐ Heparin 100 unit/ml
Port: Flush before, after each infusion, and as needed with 5-20 ml NS, followed by Heparin 100 unit/ml 5 ml.

ANAPHYLAXIS ORDERS
Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.
For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.
☐ Other: ____________________

Skilled Nursing Services Needed? ☐ Yes ☐ No Additional Instructions: ____________________

6.
PHYSICIAN'S SIGNATURE (required): ____________________ **Date:** __________

Prescription is valid for one year unless otherwise indicated. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.