

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

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*: _____	City*: _____ State*: _____
Primary language*: _____	Zip*: _____
DOB*: _____ Social Security #: _____	Office Contact: _____
Gender*: <input type="checkbox"/> M <input type="checkbox"/> F Height: _____ Weight*: _____	Phone*: _____ Fax*: _____
Specialty*: _____	
Allergies*: _____ NKA*: <input type="checkbox"/>	
Alternate contact name: _____ Alternate contact phone: _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No* Consent to leave voice message at the patient and/or alternate contact phone	
3. DIAGNOSIS (*indicates a required field) Year of diagnosis: _____	
<input type="checkbox"/> *(E05.00) Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm (hyperthyroidism)	
<input type="checkbox"/> Yes <input type="checkbox"/> No* Does the patient have documented Thyroid Eye Disease? <i>If not, the patient is not a candidate for Tepezza.</i>	
<input type="checkbox"/> 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 : <input type="checkbox"/> 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	
<input type="checkbox"/> Heparin 10 unit/ml <input type="checkbox"/> 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.	
<input type="checkbox"/> Other: _____	
Skilled Nursing Services Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No Additional Instructions: _____	
6.	
PHYSICIAN'S SIGNATURE (required) : _____ Date : _____	