

Patient Information

Name: _____ DOB: _____
Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____
Email: _____ Weight: _____ ☐ lbs ☐ kgs
Allergies: ☐ NKDA ☐ _____

Required Documentation Insurance Card | History & Physical | Patient Demographics | Medication List | Recent Thyroid Panel
Neg Pregnancy Test

CAS Score: _____ Patient Ethnicity (can affect proptosis requirements): _____
Endocrinologist's Name: _____ Ophthalmologist's Name: _____

Primary Diagnosis

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

Order Information

Lab Orders (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 BluHaven Health's protocol (see BluHaven.com for policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box.

Adverse Reaction & Anaphylaxis Orders

☒ Administer acute infusion reaction and anaphylaxis medications per BluHaven Health's protocol (see BluHaven.com for policy)
☐ Other: Please fax other reaction orders if checking this box.

Provider Information

Name: _____ Office Contact: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Fax Number: _____
Email: _____ NPI: _____

I authorize BluHaven Health and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this order and any future related orders for the patient listed above.

Provider Signature

Date