US infusions
11500 State Hwy 121 Ste 910, Frisco, TX 75035
4708 Dexter Dr., Ste 350, Plano, TX 75093
P: 469-200-2605 F: 469-200-2606 usinfusions.org

TEPEZZA (TEPROTUMUMAB) INFUSION ORDERS

PATIENT INFORMATION

Name: _____ DOB: _____ Gender: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____ Height: _____ ☐ inches ☐ cm Weight: _____ ☐ lbs. ☐ kg

Allergies: _____

Diagnosis Code ICD-10 (required): _____ **Diagnosis Description:** _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Treatment Date: _____

PHYSICIAN INFORMATION

Prescriber Name: _____ Phone: _____ Fax: _____

Office Contact: _____ Email: _____

Address: _____ City: _____ State: _____ ZIP: _____

NPI #: _____ DEA #: _____ Tax ID: _____

PRESCRIPTION INFORMATION *(or attach copy of the prescription)*

Drug	Dosing
Tepezza (teprotumumab)	☐ 10mg/kg IV for the first infusion, followed by 20mg/kg IV (3 weeks after the initial dose) every 3 weeks for 7 additional Infusions (8 total Infusions)

Lab orders: _____ Frequency: _____

Serum glucose with each dose, HgbA1C every 3 months:

☐ Before Infusion

☐ After Infusion

Preferred location for lab draw: ☐ US Infusions ☐ Referring Provider

PRESCRIBER SIGNATURE

By signing this form and receiving services from US Infusions, Inc., you hereby authorize US Infusions, Inc. and its employees or authorized representatives to serve as your designated agent for purposes of obtaining prior authorizations and coordinating specialty pharmacy services with medical and prescription benefit providers. You further authorize US Infusions, Inc. to select the most appropriate and cost-effective site of care based on clinical, insurance, and operational considerations.

Signature: _____ **Date:** _____

****PLEASE COMPLETE BOTH SIDES OF THIS FORM****

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Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1).
- ☐ Include patient demographic information and insurance information.
- ☐ Include patient's medication list.
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance benefits, or contraindications to conventional therapy.
- ☐ Has the patient had a documented contraindication/intolerance or failed trial of corticosteroids? ☐ Yes ☐ No
- ☐ Is the patient a current smoker? ☐ Yes ☐ No
  - If yes, has smoking cessation been discussed? ☐ Yes ☐ No
- ☐ Indicate any symptoms the patient has:
  - ☐ Lid retraction ≥ 2 mm
  - ☐ Moderate or severe soft tissue involvement
  - ☐ Exophthalmos ≥ 3 mm above normal for race and gender
  - ☐ Diplopia
  - ☐ Other: _____
- ☐ Include labs and/or test results to support diagnosis
  - ☐ TSH, T3, T4
- ☐ If history of diabetes, glucose is under control
  - Has the patient had a course of Tepezza previously? ☐ Yes ☐ No
- ☐ Other medical necessity: _____

Please enroll in manufacturer HUB program to the following.

Enrolled in manufacturer HUB program.

- ☐ Yes, see atached.
- ☐ No, please complete on patient's behalf.