Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226

INFUSION SOLUTIONS

Prince George
2025 Waterside Rd, Suite 100B
Prince George, VA 23875

Physician Order - Tepezza (teprotumumab-trbw)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:

REFERRAL STATUS
☐ New Referral ☐ Dose/Frequency Change ☐ Order Renewal

Location Preference (optional)
☐ Richmond ☐ Prince George

* * If the patient has a central line - we need official placement report, diagnostic imaging to confirm tip placement and date of last access * *

DIAGNOSIS AND ICD-10 CODE	
☐ Thyrotoxicosis w/ diffuse goiter w/o thyrotoxic crisis or storm (hyperthyroidism)	E05.00
☐ Other: _____	ICD10 _____

REQUIRED DOCUMENTATION (must include)	
☐ This signed order form by the provider	☐ Clinical/Progress Notes
☐ Patient Demographics AND Insurance Information	☐ Labs and Tests Supporting Primary Dx
☐ Thyroid Function Test (T4 and T3 levels)	☐ Thyroid Eye Disease Clinical Activity Score (CAS)
☐ Patient currently receiving same therapy at _____	Last dose: _____
List Tried & Failed Therapies, including duration of treatment	
1)	
2)	
3)	

MEDICATION ORDERS**	
Initial Dosing	☐ Tepezza 10mg/kg infuse IV over 90 minutes x 1 dose
Maintenance Dosing	☐ Tepezza 20mg/kg infuse IV over 90 minutes every 3 weeks x 7 doses
	*if first 2 infusions are well tolerated, may reduce subsequent infusions time to 60 minutes
Patient Weight = _____ kg	Patient Height = ____ ft ____ in
Duration: ☐ x 6 months ☐ x 1 year ☐ doses _____	

**Patient weight is required for all weight based therapies - please indicate weight in kilograms.

OPTIONAL PREMEDICATIONS and LAB ORDERS
☐ Acetaminophen 650mg PO prior to infusion
☐ Diphenhydramine 25mg PO or IV (per patient preference) prior to infusion
☐ Methylprednisolone 40mg slow IVP prior to infusion
☐ Other PreMed or Lab Order with frequency:

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION		
Prescriber Name:	NPI:	Contact:
Phone:	Fax:	Email:
Prescriber Signature:		Date:

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com
Fax completed form and ALL required documentation to 804-554-5848
All information contained in this form is strictly confidential and will become part of the patient's record.