

## Community Health Interventions Specialty Clinic

### INFUSION ORDERS-TEPEZZA (TEPROTUMUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS		
<input type="checkbox"/> New Referral	<input type="checkbox"/> Dose or Frequency Change	<input type="checkbox"/> Order Renewal

DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Thyroid Eye Disease	ICD 10 Code: E05.00
<input type="checkbox"/> Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis <input type="checkbox"/> Labs and Tests supporting primary diagnosis

MEDICATION ORDERS
Initial IV dose: <input type="checkbox"/> Tepezza 10mg/kg IV once, initial dose  Maintenance Dosing (will start 3 weeks after initial dose, when applicable): <input type="checkbox"/> Tepezza 20mg/kg IV every 3 weeks x 7 doses  Other (please include dose, route, frequency, and number of refills): <input type="checkbox"/> Tepezza _____  PLEASE NOTE: First and second doses will be administered over 90 minutes, and if tolerated, subsequent doses will be administered over 60 minutes.  Patient weight (kg): _____

PHYSICIAN INFORMATION		
Prescribing Physician:		
Office Phone:	Office Fax:	Office Email:
Physician Signature:		Date:

**Contact us with questions at: [jeff@eastoninfusion.com](mailto:jeff@eastoninfusion.com) or call 728-777-5546**

Fax completed form and all documentation to **(561) 709-8626**

All information contained in this form is strictly confidential and will become part of the patient's medical record.