MRN:______________________

DOB:______________________

Standard Tepezza® (teprotumumab-trbw) Plan of Treatment

NOTE: We require MD office notes to support clinical treatment and may require a Letter of Medical Necessity (depending on diagnosis), to be able to verify eligibility and payment for this treatment through patient Medicare and/or other insurance plan.

1. Patient Name:_____________________________________ Height (inches):_____ Weight (lbs):_____

2. Allergies:

3. Diagnosis: ☐ E05.00 **Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm**

☐ **Other** *ICD-10 Code* (Diagnosis/Description):____

4. Pre-medications: ***Administered 30 minutes prior to infusion as selected:***

Acetaminophen:	Diphenhydramine: ☐ 25 mgs PO, ☐ 50mgs PO, ☐ 25 mgs IVP, ☐ 50mgs IVP or
☐ 1000 mgs PO	Alternate oral antihistamine to diphenhydramine: ☐ Cetirizine 10 mg,
☐ 650mgs PO	☐ Loratadine 10 mg, Fexofenadine ☐ 60mgs or ☐ 180mgs
☐ 500mgs PO	Methylprednisolone ☐ 40mgs IVP ☐ 125mgs IVP or other_____mgs IVP
☐ 325mgs PO	

Pre-medicate with other: ____

5. Dose: Initial dose: Intravenous infusion of 10 mg/kg over 90 minutes

Subsequent dosing: Intravenous infusion of 20 mg/kg every three weeks for 7 infusions.

***Total of 8 infusions to be given. ***

Infusion # 2 to be infused over 90 minutes.

Infusions 3-8 to be infused over 60 minutes.

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

Special orders:____

7. Physician's Signature:________________________/______________________Date: ______________

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials:______________________________________NPI: ___________________

MRN:______________________

DOB:______________________

Guidelines for Prescribing Tepezza® (teprotumumab) Plan of Treatment

(Required documentation with all initial referrals)

Patient Name: ____ **Referral Date:**______________________

☐ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-8)*

(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

☐ Include patient demographic information and insurance information. (Copy of insurance cards if

☐ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**

Other as requested: ____

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.