Referral Status:			MRN:
☐ New referral	☐ Order change	☐ Order Renewal	
Patient preferred clinic:			

Tepezza® (teprotumumab-trbw) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:	Patient's Phone:
Patient Name:	Address:
Date of Birth:	City, State, Zip:
Height in inches: / Weight: LB or KG	Gender: / Allergies: ☐ See list ☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	E05.00 - Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm
☐	_______ - Other:

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	
6	

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:	IF YES:
PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
	NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMNISTRATION AS SELECTED

IV

Medication					
Diphenhydramine	☐	25mg	☐	50mg	
Methylprednisolone	☐	40mg	☐	125mg	☐ Other:
Famotidine	☐	20mg	☐	40 mg	
Other:	☐				

PO

Medication								
Acetaminophen	☐	325mg	☐	500mg	☐	650mg	☐	1000mg
Famotidine	☐	20mg	☐	40mg				
Diphenhydramine	☐	25mg	☐	50mg				
Fexofenadine	☐	60mg	☐	180mg				
Cetirizine	☐	10mg						
Loratadine	☐	10mg						
Other:	☐							

MEDICATION:

☑ Tepezza® (teprotumumab-trbw) diluted in 100--250ml NS

DOSE:

☐ Initial dose: Intravenous infusion of 10 mg/kg

Infusion #1 infused over 90 minutes

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

Infusion #2 infused over 90 minutes

Infusion #3-8 infused over 60 minutes

☐ Other:_______________________________________

SPECIAL/LAB ORDERS:

☐ _______________________________________

____

Refills:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)

		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- ☐ **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**

Palmetto Infusion 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. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

www.PalmettoInfusion.com

02/10/2023

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