Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

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	Free T3 and T4
6	

IF NO: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF YES:

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

PO	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 infused IV

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

CONTINUATION OF THERAPY:

Patient has received ____ doses with previous provider; Palmetto Infusion Services to provide remainder of subsequent doses as noted above

LAB ORDERS:

☐ Finger Stick Blood Glucose with each dose

Hold/call parameters: _____

_____

*If hold/call parameters are not included, will follow PIS protocol

☐ Pregnancy Test, Urine: Prior to each infusion

☐ Other lab orders _____

SPECIAL/OTHER ORDERS:

☐ _____

☑ Refills:

NURSING ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

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	

PATIENT ENROLLMENT FORM

Submit a completed form by fax 1-833-469-8333 or email TEPEZZAHBYS@horizontherapeutics.com

Initiate the patient enrollment process by completing ALL REQUIRED FIELDS indicated by *. For patient support and/or assistance obtaining patient signature, call Horizon By Your Side at 1-833-5-TEPEZZA (1-833-583-7399).

HORIZON BY your side | TEPEZZA® teprotumumab-trbw

P-TEP-US-00323-5

PATIENT INFORMATION

First name* _____ Last name* _____ Sex: ○ Male ○ Female

Date of birth*: ____/____/____ (MM/DD/YYYY)

Primary language _____

Primary Phone Number* _____ ○ Home ○ Cell

Consent to:
Send text message? ○ Yes ○ No
Leave voice message? ○ Yes ○ No

Email address _____

Address* _____

City* _____ State* _____ Zip code* _____

Alternate contact name _____ Alternate contact telephone _____

DIAGNOSIS (Required for benefits investigation.)

○ **Primary diagnosis code*** E05.00 — Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm (hyperthyroidism)

Additional disease manifestation codes: _____

Date of initial Thyroid Eye Disease (TED) diagnosis: _____/_____ (MM/YYYY)

Patient's Clinical Activity Score (CAS) [0-10 Range]: _____

INSURANCE INFORMATION

Complete the following OR attach front-back copies of insurance card(s).

Primary Insurance*	Secondary Insurance
Policy #*	Policy #
Policyholder's first and last name*	Policyholder's first and last name
Insurance company telephone*	Insurance company telephone
Group #*	Group #
Policyholder's DOB*: ____/____/____ (MM/DD/YYYY)	Policyholder's DOB: ____/____/____ (MM/DD/YYYY)
IPA/Medical group Name	IPA/Medical group Phone Number

○ Patient is uninsured to my knowledge.

State requirements: The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

PATIENT AUTHORIZATION

X _____ **Patient signature** Please read page 2

Date (MM/DD/YYYY) ____/____/____

_____ **Printed full name**

Please see Important Safety Information on next page and Full Prescribing Information at TEPEZZAhcp.com.

PRESCRIBER INFORMATION

First name* _____ Last name* _____

Address* _____

City* _____ State* _____ Zip code* _____

NPI #* _____ Tax ID #* _____ State license #* _____

Clinic/hospital affiliation _____

Office contact name* _____ Office contact telephone* _____

Office Contact Email Address* _____ Fax* _____

Specialty: _____ Preferred communication: ○ Telephone ○ Email

REFERRING PHYSICIAN (Complete if patient was sent to you by another physician. They will be part of the patients care team.)

First and Last Name _____ Specialty _____

Address _____

City _____ State _____ Zip code _____ Telephone _____

PREFERRED INFUSION FACILITY (If none, Horizon By Your Side can provide options.)

Sage Infusion — Facility name

intake@sageinfusion.com — Email

Address _____

City _____ State _____ Zip code _____ Telephone _____

1013578442 — Facility NPI #

84-1874532 — Tax ID #

PRESCRIPTION (Required for specialty pharmacy benefit or home infusion.)

Medication: TEPEZZA® (teprotumumab-trbw) for injection, for intravenous use//500-mg vial

Directions: 1 peripheral IV infusion every 3 weeks for a total of 8 infusions. Administer the first 2 infusions over 90 minutes. Subsequent infusions may be reduced to 60 minutes, if tolerated. Please see Dosing and Administration section of Prescribing Information for additional instruction.

Dose*: Infusion 1: _____ mg (10mg/kg) 21-day supply; 1 prescription; no refill

Infusions 2-8: _____ mg (20mg/kg) 21-day supply; 1 prescription; 6 refills

Weight*: _____ ○ lbs ○ kg

TEPEZZAdosing.com

Allergies*: _____ or ○ No known drug allergies (NKDA)

○ Patient is Medically Urgent. I attest the patient is both (1) is experiencing compressive optic neuropathy secondary to Thyroid Eye Disease and (2) requires accelerated treatment with TEPEZZA.

○ **Nursing orders for home infusion:** Provide skilled nursing visit to administer medication, provide education, and assess patient (required for home infusion). Saline flushes and other administration supplies authorized as needed.

Fluids for reconstitution/administration: Reconstitute each vial with 10 mL of Sterile Water for Injection, USP. Administer via an infusion bag containing 0.9% Sodium Chloride Injection, USP. For doses <1800 mg, use a 100 mL bag. For doses ≥ 1800 mg, use a 250 mL bag.

PRESCRIBER CERTIFICATION (Required—please see certification language on the next page.)

X _____ **Prescriber signature/Dispense as written*** **Date** (MM/DD/YYYY) ____/____/____

_____ Substitutions allowed

Written or e-signature only; stamps not acceptable.

○ **I certify that the above therapy is medically necessary for the treatment of documented Thyroid Eye Disease (TED)*** The above signature grants permission to share records with the co-management team and infusion facility.

Prescriber Certification

Please read and provide signature in Prescriber Certification section on page 1

I certify that the above therapy is medically necessary, that the information provided is accurate to the best of my knowledge and that my patient is being administered TEPEZZA (teprotumumab-trbw), for intravenous infusion in accordance with the labeled use of the product. I understand that Horizon Therapeutics USA, Inc. and its affiliates and their respective employees or agents (collectively, "Horizon") will use this information to administer the Horizon By Your Side program (the "Program"), which provides a wide array of patient-focused services, including providing logistical and non-medical treatment support for TEPEZZA, as prescribed, and educating about the insurance process. I authorize these parties to act on my behalf for the limited purposes of transmitting this prescription by facsimile to the appropriate pharmacy designated by the patient utilizing their benefit plan. By my signature, I also certify that (1) my patient or his/her personal representative has provided a signed HIPAA authorization that allows me to share protected health information with Horizon for purposes of the Program and (2) I have obtained the patient's authorization to release such information as may be required for AllCare Plus Pharmacy (or another party acting on behalf of Horizon) to assess insurance coverage for TEPEZZA and assistance in initiating or continuing TEPEZZA as prescribed. I further understand and agree that (a) any medication or service provided through the Program as a result of this form is for the named patient only and is not being made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use TEPEZZA or any other Horizon product or service, for any other person; (b) my decision to prescribe TEPEZZA was based solely on my professional determination of medical necessity; and (c) I will not seek reimbursement for any medication or service provided by or through the Program from any government program or third-party insurer. I understand that Horizon may modify or terminate the Program at any time without notice. The completion and submission of coverage- or reimbursement-related documentation are the responsibility of the patient and healthcare provider. Horizon makes no representation or guarantee concerning coverage or reimbursement for any item or service. On behalf of the patient, Horizon expects the prescriber to coordinate with Horizon By Your Side to provide, to the best of the prescriber's ability, in-network infusion services and work with Horizon By Your Side to effectively communicate both in-network and out-of-network choices and the corresponding financial obligations of the patient connected to each choice. Should the prescriber knowingly perform out-of-network services without the knowledge and consent of the patient, the prescriber cannot balance bill the patient for the out-of-network services.

State requirements: The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

By filling out and signing this form, the enrollment process in Horizon By Your Side has initiated; however, your patient must sign a Patient Authorization to complete enrollment in Horizon By Your Side. Please note that your patient will not benefit from the services and support offered by the Program unless your patient signs a Patient Authorization, consenting to receiving such services. If your patient does not sign the Patient Authorization contained within this form, Horizon will contact the patient to determine whether the patient is interested in signing a separate Patient Authorization.

Patient Consent for Patient Information, Enrolling in Services, and Accessing Financial Support (referred to as "Patient Authorization")

Please read and provide signature in Patient Authorization section on page 1

I hereby authorize my healthcare providers, my health insurance carriers, and my pharmacies to use and disclose my individually identifiable health information, including my medical records, insurance coverage information, and my name, address, and telephone number to Horizon Therapeutics USA, Inc. and its affiliates and their respective agents and representatives (collectively, "Horizon"), including third parties authorized by Horizon to administer drug support and to dispense drugs (collectively, "Horizon By Your Side") for the following purposes: (1) to establish eligibility for benefits; (2) to communicate with my healthcare providers and me about my treatment or condition and related products; (3) to facilitate the provision of products, supplies, or services by a third party including, but not limited to, specialty pharmacies; (4) to register me in any applicable product registration program required for my treatment; (5) to enroll me in eligible patient support programs offered by Horizon By Your Side and/or Horizon, including nursing or patient access support services (government-reimbursed programs may not be eligible for all support services offered; please contact Horizon By Your Side for determination); and (6) to send me marketing information or offer me products and services related to my treatment or condition (or other products or services in which I might be interested) and to contact me occasionally to obtain my feedback (for market research purposes only) about my treatment, my condition, or my experience with Horizon and/or Horizon By Your Side otherwise as required or permitted by law. Further, I appoint the Program, on my behalf, to proceed with Program services and to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. I understand the pharmacies may receive a fee from Horizon in exchange for (1) providing me with certain materials and information described above, and (2) using or disclosing certain health information pursuant to this Authorization.

I understand that Horizon, as well as my healthcare providers, cannot require me, as a condition of having access to medications, prescription drugs, treatment, or other care, to sign this Authorization. I understand that I am entitled to a copy of this Authorization.

I understand that information disclosed pursuant to this Authorization in some cases may be redisclosed by the recipient and no longer protected by HIPAA or other privacy laws. But Horizon has agreed to use and disclose my information only for purposes of operating the Program. I understand that I may cancel this Authorization at any time by mailing a signed letter requesting such cancellation to Horizon By Your Side, 1 Horizon Way, Deerfield, IL 60015, but that this cancellation will not apply to any information used or disclosed by my healthcare providers and/or health insurance carriers based on this Authorization before they are notified that I have cancelled it. Unless required by state law, this Authorization is valid for whichever is greater: (a) the duration remaining on this treatment or (b) 10 years from the date signed on page 1. A photocopy of this Authorization will be treated in the same manner as the original.

INDICATION

TEPEZZA is indicated for the treatment of Thyroid Eye Disease regardless of Thyroid Eye Disease activity or duration.

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Infusion Reactions: TEPEZZA may cause infusion reactions. Infusion reactions have been reported in approximately 4% of patients treated with TEPEZZA. Reported infusion reactions have usually been mild or moderate in severity. Signs and symptoms may include transient increases in blood pressure, feeling hot, tachycardia, dyspnea, headache, and muscular pain. Infusion reactions may occur during an infusion or within 1.5 hours after an infusion. In patients who experience an infusion reaction, consideration should be given to premedicating with an antihistamine, antipyretic, or corticosteroid and/or administering all subsequent infusions at a slower infusion rate.

Preexisting Inflammatory Bowel Disease: TEPEZZA may cause an exacerbation of preexisting inflammatory bowel disease (IBD). Monitor patients with IBD for flare of disease. If IBD exacerbation is suspected, consider discontinuation of TEPEZZA.

Hyperglycemia: Increased blood glucose or hyperglycemia may occur in patients treated with TEPEZZA. In clinical trials, 10% of patients (two-thirds of whom had preexisting diabetes or impaired glucose tolerance) experienced hyperglycemia. Hyperglycemic events should be controlled with medications for glycemic control, if necessary. Assess patients for elevated blood glucose and symptoms of hyperglycemia prior to infusion and continue to monitor while on treatment with TEPEZZA. Ensure patients with hyperglycemia or preexisting diabetes are under appropriate glycemic control before and while receiving TEPEZZA.

Hearing Impairment Including Hearing Loss: TEPEZZA may cause severe hearing impairment including hearing loss, which in some cases may be permanent. Assess patients' hearing before, during, and after treatment with TEPEZZA and consider the benefit-risk of treatment with patients.

ADVERSE REACTIONS

The most common adverse reactions (incidence ≥5% and greater than placebo) are muscle spasm, nausea, alopecia, diarrhea, fatigue, hyperglycemia, hearing impairment, dysgeusia, headache, dry skin, weight decreased, nail disorders, and menstrual disorders.

Please see Full Prescribing Information or visit TEPEZZAhcp.com for more information.

HORIZON®

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teprotumumab-trbw