VEROS HEALTH
Excellence in Complex Care

Teprotumumab-trbw (Tepezza®) Referral Form

Please complete the following and fax with clinical documentation to 720.870.2414

Referral Process

1. PATIENT INFORMATION (*indicates a required field)

Name*: _____

Address*: _____

City*: _____ State*: _____ Zip*: _____

Home Phone: _____ Mobile Phone*: _____

Email*: _____

Primary language*: _____

DOB*: _____ Social Security #*: _____

Gender*: ☐ M ☐ F Height: _____ Weight*: _____

2. PHYSICIAN INFORMATION (*indicates a required field)

Physician's name*: _____

License #: _____ NPI #*: _____

DEA #: _____ Email*: _____

Address*: _____

City*: _____ State*: _____

Zip*: _____

Office Contact: _____

Phone*: _____ Fax*: _____

Specialty*: _____

Allergies*: _____ NKA*: ☐

Alternate contact name: _____ Alternate contact phone: _____

☐ Yes ☐ No* Consent to leave voice message at the patient and/or alternate contact phone

3. DIAGNOSIS (*indicates a required field) Year of diagnosis: _____

☐ *(E05.00) Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm (hyperthyroidism)

☐ Yes ☐ No* Does the patient have documented Thyroid Eye Disease? ***If not, the patient is not a candidate for Tepezza.***

☐ Other diagnoses: _____

4. INSURANCE INFORMATION

Please submit copies of the front and back of primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION Anticipated Start Date: _____

Prescription*: Teprotumumab-trbw (Tepezza®) 500 mg vial for intravenous use
Prior to administration, dilute doses <1800mg in 100 mLs 0.9% Sodium Chloride and doses ≥ 1800mg in 250 mLs 0.9% Sodium Chloride.

Duration: 1 infusion every 3 weeks for a total of 8 infusions. Administer the first two infusions over 90 minutes. If well tolerated, subsequent infusions may be reduced to 60 minutes.

Dose: Week 0: _____ mg (10mg/kg) Week 3: _____ mg (20mg/kg)
21 day supply; 1 prescription; no refill 21 day supply: 1 prescription; 6 refills; q3wks

Premedication orders: _____

Additional orders: _____

Access: ☐ Peripheral Other: _____

FLUSH ORDERS

PIV/midline/PICC: Flush before, after each infusion, and as needed with 3-20 ml NS, followed by Heparin 2-5 ml if indicated
☐ Heparin 10 unit/ml ☐ Heparin 100 unit/ml

Port: Flush before, after each infusion, and as needed with 5-20 ml NS, followed by Heparin 100 unit/ml 5 ml.

ANAPHYLAXIS ORDERS

Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.
For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.
☐ Other: _____

Skilled Nursing Services Needed? ☐ Yes ☐ No Additional Instructions: _____

6.

PHYSICIAN'S SIGNATURE (required): _____ **Date:** _____

Prescription is valid for one year unless otherwise indicated. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.