

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to (315) 457-4305

Phone (315) 457-3091

1. PATIENT INFORMATION

Name:		DOB:	
Phone:		Other Phone:	
Email:			
Social Security #:		Allergies:	
Gender:	M F	Weight:	Lbs Kg
Patient Status: New to therapy Continuing therapy Next due date (if applicable):			

2. INSURANCE INFORMATION (required)

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

3. PHYSICIAN INFORMATION

Physician Name:		NPI#:	
License #:	TIN#:	DEA#:	
Address:			
City:		State	Zip
Office Contact:		Email:	
Office phone:		Office fax:	

4. DIAGNOSIS INFORMATION (ICD 10 Code Required)

Thyroid Eye Disease(_____)

Other: _____

***Baseline hearing test required**

5. PRESCRIPTION INFORMATION (requires new order every 12 months) *Free T3, T4 and CAS required prior to initial infusion

TEPEZZA	Initial	Maintenance	PRE-MEDICATIONS	N/A
Initial Dose: Administer _____ mg at 10mg/kg at week 0			Acetaminophen 500mg 650mg 1000mg	
Maintenance Dose: Administer Q3 weeks; _____ mg at 20mg/kg x 7 infusions			Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)	
Vital signs per HI Protocol			Diphenhydramine (Benadryl) 25mg 50mg PO IV (requires driver)	
Anaphylaxis & Hydration Management per HI Protocol			Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV	
			Prednisone _____ mg PO	
			Other _____	
			POST-MEDICATIONS	N/A
			Acetaminophen 500mg 650mg 1000mg	
			Prednisone _____ mg PO	
			Other _____	

6. LABS

CBC w/Diff	Each Infusion	Other Frequency (specify): _____
CRP	Each Infusion	Other Frequency (specify): _____
CMP	Each Infusion	Other Frequency (specify): _____
ESR	Each Infusion	Other Frequency (specify): _____
Hepatic Panel	Each Infusion	Other Frequency (specify): _____
Renal Panel	Each Infusion	Other Frequency (specify): _____
Quantiferon TB Gold, annually, last completed (date): _____		
Other (specify): _____		

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE