



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

Fax completed form to (724) 240-1586

Phone (724) 510-3702

1. PATIENT INFORMATION

| | | | |
|---|----------|--------------|-------------|
| Name: | | DOB: | |
| Phone: | | Other Phone: | |
| Email: | | | |
| Social Security #: | | Allergies: | |
| Gender: | M F | Weight: | Lbs Kg |
| Patient Status: <input type="checkbox"/> New to therapy <input type="checkbox"/> 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

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

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