

# Tepezza® (Teprotumumab)

## Referring Physician Order Form

Please fax completed referral form & all required documents to 208-595-4427



### PATIENT DEMOGRAPHICS

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City/ST/Zip: \_\_\_\_\_  
Allergies: \_\_\_\_\_ ☐ NKDA Weight: \_\_\_\_\_ ☐ lbs ☐ kg Height: \_\_\_\_\_ ☐ in ☐ cm  
Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

**INSURANCE INFORMATION: Please attach copy of insurance card (front and back).**

### DIAGNOSIS\*

\*ICD 10 Code Required ☐ Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm, ICD10: E05.00  
☐ Other: \_\_\_\_\_ ICD10: \_\_\_\_\_

### INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Tepezza® (teprotumumab)	<input type="checkbox"/> Initial Dose: _____ mg (10 mg/kg) <input type="checkbox"/> Subsequent Doses: _____ mg (20 mg/kg)	<input type="checkbox"/> Initial: Infuse IV over 90 minutes x 1 dose. <input type="checkbox"/> Subsequent: Infuse IV over 90 minutes every 3 weeks x _____ doses. (maximum 7) *If first 2 infusions are well tolerated, may reduce subsequent infusion times to over 60 minutes.

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: \_\_\_\_\_

Date of last treatment: \_\_\_\_\_ Date of next treatment: \_\_\_\_\_

### PRE-MEDICATION ORDERS

☐ No premeds ordered at this time  
☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO  
☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP  
☐ Other: \_\_\_\_\_

### LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician  
☐ No labs ordered at this time  
☐ Blood glucose q \_\_\_\_\_ ☐ CBC with diff/platelet q \_\_\_\_\_  
☐ CMP q \_\_\_\_\_ ☐ Other: \_\_\_\_\_

### REFERRING PHYSICIAN INFORMATION

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Physician Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ City/ST/Zip: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Email Where Follow Up Documentation Should Be Sent: \_\_\_\_\_

### REQUIRED CLINICAL DOCUMENTATION

**Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.**

#### ☐ See Attached Medical Records

☐ Yes ☐ No Is active Thyroid Eye Disease (TED) confirmed with a baseline Clinical Activity Score (CAS) of  $\geq 4$  in the more severely affected eye?

☐ Yes ☐ No Does the patient present with at least ONE of the following features of moderate-to-severe TED?

If yes, please select all that apply:

- ☐ Lid retraction  $\geq 2$ mm  
☐ Moderate or severe soft tissue involvement  
☐ Exophthalmos  $\geq 3$ mm above normal for race and gender  
☐ Intermittent or constant diplopia  
☐ Other: \_\_\_\_\_

☐ Yes ☐ No Is patient euthyroid or currently receiving treatment to correct mild hypo- or hyperthyroidism (e.g., free T4 and free T3 levels are  $< 50\%$  above or below normal limits)?

### LAB AND TEST RESULTS (required)

☐ Thyroid Eye Disease (TED) Clinical Activity Score (CAS) report  
☐ Thyroid functions tests (free thyroxine [T4], free triiodothyronine [T3])  
☐ Other: \_\_\_\_\_

### PRIOR FAILED THERAPIES

Medication Failed: \_\_\_\_\_ Dates of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_  
Medication Failed: \_\_\_\_\_ Dates of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_  
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Medication Failed: \_\_\_\_\_ Dates of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_