Please fax completed form, insurance card, and clinical documentation to:
FAX: 410-220-2553

TEPEZZA ORDER ☐ **New Start** ☐ **Maintenance: Last Dose Given_____________**
#doses already given__________

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	

Allergies ☐ NKDA ☐ Allergies:

____ Height:

_______________________ Weight: ________________

Indication (ICD-10-CM):
☐ H_____
☐ Other____

DOSAGE ORDERS:
☐ Loading dose: 10mg/kg then
☐ Maintenance: 20mg/kg every 3 weeks for 7 additional infusions
☐ Other ____

PREMEDICATION ORDERS: *not required by PI*
☐ Acetaminophen po: ☐ 1000mg ☐500mg 30 min prior to infusion. ☐ Diphenhydramine: ☐ 25mg PO ☐ 50mg PO ☐ 25mg IVP 30 min prior to infusion. ☐ Solu-Medrol: ☐ 62.5mg IVP ☐ 100mg IVP ☐ Other______ 30 min prior to infusion. ☐ Other ____

Prescriber Name: Title:	
NPI:	DEA:

Prescriber Signature: Date of Order:

Referrals will not be processed until we receive ALL the following:

☐ Face Sheet / Patient Demographics

☐ Insurance card(s) – copy of front & back

☐ Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes) Most Recent Labs (within last 4-8 weeks) – Required:

☐ CBC ☐ CMP ☐ TB ☐ Hep B Other: ____