TEPEZZA
(teprotumumab-trbw)

FLOURISH™ HEALTH GROUP

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Medication List
- Recent Thyroid Panel
- Negative Pregnancy Test
- CAS of 4 or Greater

- Endocrinologist's Name: _____
- Opthalmologist's Name:_____

PRIMARY DIAGNOSIS

☐ E05.00 Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

*HgbA1c will be drawn at baseline and every 3 months while on therapy, per Flourish Health Group's protocol (no cost to payor or patient).

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Tepezza
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

**Patients with pre-existing diabetes should be under appropriate glycemic control before receiving Tepezza.
☐ Tepezza 10 mg/kg (___mg) IV followed by 20 mg/kg (___mg) IV every 3 weeks for seven additional treatments
☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Flourish Health Group's protocol (See flourishhealth.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Flourish Health Group's protocol
(See flourishhealth.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date