TEPEZZA Referral Form **Date:**_______________	**Evolutionary Pharmacy Solutions** **Fax Referral To: 1-800-239-0363** **Phone: 1-844-800-5377**	

PATIENT INFORMATION:

Last Name:	First Name:	Home Phone:	Mobile:
Home Address:	City:	State:	Zip:
Delivery Address:	City:	State:	Zip:
Date of Birth:	Gender:	Language:	Email:
Caregiver Name:		Relationship:	Number:

HEATLHCARE PROVIDER INFORMATION

Practice Name:	Dr Name:	Phone:	Fax
Address:	City:	State:	Zip:
NPI:	DEA:	License:	UPIN:

INSURANCE INFORMATION *Provide Copy of Front & Back of Insurance Card *

Insurance Name:	Insurance Name:	
ID Number:	ID Number:	PCN:
Group Number:	Group Number:	BIN:

CLINICAL INFORMATION * Provide Medical Records *

TED: ☐ Yes ☐ No **Diagnosis:** ☐ E05.00 ☐ E06.3 ☐ Other (specify):_____________________ | Pregnancy Test: ☐ Negative ☐ Using Contraceptive Method

Other Comorbidities:____ | Weight:

Therapy: ☐ New to Therapy ☐ Continuing Therapy ☐ Next Due Date (if applicable):________________________ | ☐ CAS Score (0-10) __________________

Laboratory Orders: ☐ CBC ☐ At Each Dose ☐ Every_____________ ☐ CMP ☐ At Each Dose ☐ Every_____________ ☐ Other: ________________________

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Tepezza (teprotumumab-trbw)	☐ 500mg single dose vial	☐ Week 0: 10 mg/kg IV for 1st infusion. Dose: _________	☐ 21 day supply	
		☐ Week 3: 20 mg/kg IV every 3 weeks for 7 infusions Dose: _________		

Reconstitute Tepezza vial with 10ml Sterile Water & gently swirl. **Dilute** with 0.9% Sod Chl. For doses < 1800mg use a 100ml bag & doses ≥ 1800mg use a 250mg bag. Discard 10.5ml of 0.9% Sodium Chloride from bag prior to adding diluted Tepezza into bag.

Administer the first 2 infusions over 90 minutes. Subsequent infusions may be reduced to 60 minutes if well tolerated. If infusion reaction occurs, interrupt or slow the rate of infusion.

Pre – Medication ** Not required but if patient experiences infusion reaction, consider premedicating 30 minutes prior infusion **

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Acetaminophen (Tylenol)	☐ 500mg ☐ 650mg ☐ 1000mg PO			
☐ Diphenhydramine (Benadryl)	☐ 25mg ☐ 50mgg ☐ PO ☐ IV			
☐ Methylprednisolone (Solu-Medrol)	☐ 40mg ☐ 125mg IV			
☐ 0.9% Sodium Chloride	☐ 5ml syringe ☐ 10 ml syringe	Flush per protocol following infusion		
☐ Anaphylaxis Medication Kit				
☐ Other:				

Nursing Coordination:
☐ **YES:** Provide home health nursing for ☐ education/training ☐ to administer ☐ reaction management ☐ 30 minute post-procedure observation.
☐ **NO:** Nursing not necessary:☐ Patient and/or caregiver are proficient with infusion ☐ Physician to administer in the office
☐ Nursing already established, if so provide agency contact information: ______________________________

PRESCRIBER SIGNATURE: ______________________________**DATE:**______________
Verbal Readback ☐ Yes ☐ No ***Stamp signature not allowed, physician signature required ***

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