

**TEPEZZA**  
**IV INFUSION**  
**PATIENT REFERRAL FORM**

Referral Fax: (304) 974-3341  
Referral Email: AHShomeinfusion@wvumedicine.org  
Phone: (304) 974-3340  
If external referral (patient outside WVU Medicine),  
also attach a copy of patient demographics, insurance  
information, & pertinent clinical notes/labs.

ORDERING PROVIDER:		OFFICE CONTACT:	
OFFICE/ADDRESS:		PHONE:	FAX:
<b>PATIENT INFORMATION</b>			
NAME:	DOB:	SEX: <input type="checkbox"/> M <input type="checkbox"/> F	
ALLERGIES:	MRN:	PHONE:	
ADDRESS:			
PRIMARY DIAGNOSIS: <input type="checkbox"/> E05.00 - Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm [hyperthyroidism] Additional ICD-10 codes: <input type="checkbox"/> H05.20 <input type="checkbox"/> H16.219 <input type="checkbox"/> H02.539 <input type="checkbox"/> H53.2 <input type="checkbox"/> H02.209 <input type="checkbox"/> Other: _____			HT: <input type="checkbox"/> cm <input type="checkbox"/> in WT: <input type="checkbox"/> kg <input type="checkbox"/> lb
EMERGENCY CONTACT:			PHONE:
<b>PRE-MEDICATIONS</b>		<b>PRN / EMERGENCY MEDICATIONS</b>	
<input type="checkbox"/> N/A <i>*Note that pre-medications are typically only administered with Tepezza if the patient has a history of infusion reaction</i> <input type="checkbox"/> acetaminophen 650 mg ORAL once 30-60 minutes prior to infusion <input type="checkbox"/> diphenhydramine 25 mg ORAL once 30-60 minutes prior to infusion <input type="checkbox"/> methylprednisolone 125 mg IV once 30 minutes prior to infusion <input type="checkbox"/> other: _____		<input type="checkbox"/> epinephrine 0.5 mg IM once; may be repeated every 5-15 minutes, if needed, for 3 total doses <input type="checkbox"/> diphenhydramine 25-50 mg IV once if needed <input type="checkbox"/> hydrocortisone 100 mg IV once if needed <input type="checkbox"/> acetaminophen 650 mg ORAL once if needed <input type="checkbox"/> other / per provider protocol (specify & attach): _____	
<b>INFUSION THERAPY</b>			
<input type="checkbox"/> teprotumumab-trbw (Tepezza) 500 mg vial in 0.9% NaCl IV infusion (In 100 mL for doses < 1800 mg; In 250 mL for doses ≥ 1800 mg) DOSE/FREQUENCY: <input type="checkbox"/> Initial: _____ mg (10 mg/kg) for initial (week 0) IV infusion once for 1 dose; 0 refills <i>*Initial dose to be administered in controlled setting (i.e., infusion center, not home infusion)</i> <input type="checkbox"/> Subsequent: _____ mg (20 mg/kg) IV infusion once every 3 weeks for 7 doses Remaining doses authorized: _____ Date last dose given: _____ ADMINISTRATION: <input type="checkbox"/> Infuse first & second doses over 90 minutes; may reduce subsequent infusions to 60 minutes, if tolerated <input type="checkbox"/> Supplies authorized as needed for administration			
<b>NURSING ORDERS</b>			
<input type="checkbox"/> Infusion nurse visits to start/remove peripheral IV access, administer medication, and assess & educate patient <input type="checkbox"/> Flush venous access with 0.9% NaCl 3-10 mL before and after med administration, as appropriate <input type="checkbox"/> Verify completion of pre-labs prior to infusion (provider to place orders with lab separately): <input type="checkbox"/> Blood glucose (non-fasting) – Hold infusion & notify provider if glucose is <70 or >250 <input type="checkbox"/> HCG serum/urine pregnancy test – Hold infusion & notify provider if positive pregnancy test <input type="checkbox"/> Stop infusion and notify provider if hypersensitivity or infusion-related reaction develops <input type="checkbox"/> Educate patient on s/s of reaction and monitor patient for <u>at least 90 minutes</u> post infusion <input type="checkbox"/> Other: _____			
<b>PRESCRIBING PHYSICIANS SIGNATURE</b>		<b>NPI</b>	<b>DATE</b>
_____ The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize Allied Health Solutions and/or its affiliates to complete and submit prior authorization (PA) requests to payers for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.		_____	_____

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