Allied HEALTH SOLUTIONS
HOME INFUSION
An affiliate of WVUMedicine

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:

PATIENT INFORMATION

NAME:	DOB:	SEX: ☐M ☐F
ALLERGIES:	MRN:	PHONE:
ADDRESS:		
PRIMARY DIAGNOSIS: ☐E05.00 - Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm [hyperthyroidism] Additional ICD-10 codes: ☐H05.20 ☐H16.219 ☐H02.539 ☐H53.2 ☐H02.209 ☐Other:_____		HT: ☐cm ☐in WT: ☐kg ☐lb
EMERGENCY CONTACT:		PHONE:

PRE-MEDICATIONS	PRN / EMERGENCY MEDICATIONS
☐N/A **Note that pre-medications are typically only administered with Tepezza if the patient has a history of infusion reaction* ☐acetaminophen 650 mg ORAL once 30-60 minutes prior to infusion ☐diphenhydramine 25 mg ORAL once 30-60 minutes prior to infusion ☐methylprednisolone 125 mg IV once 30 minutes prior to infusion ☐other: _____	☐epinephrine 0.5 mg IM once; may be repeated every 5-15 minutes, if needed, for 3 total doses ☐diphenhydramine 25-50 mg IV once if needed ☐hydrocortisone 100 mg IV once if needed ☐acetaminophen 650 mg ORAL once if needed ☐other / per provider protocol (specify & attach): _____

INFUSION THERAPY

☐ 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:
- ☐ Initial: _____ mg (10 mg/kg) for initial (week 0) IV infusion once for 1 dose; 0 refills
  **Initial dose to be administered in controlled setting (i.e., infusion center, not home infusion)*
- ☐ Subsequent: _____ mg (20 mg/kg) IV infusion once every 3 weeks for 7 doses
  Remaining doses authorized: _____ Date last dose given: _____

ADMINISTRATION:
- ☐ Infuse first & second doses over 90 minutes; may reduce subsequent infusions to 60 minutes, if tolerated
- ☐ Supplies authorized as needed for administration

NURSING ORDERS

☐ Infusion nurse visits to start/remove peripheral IV access, administer medication, and assess & educate patient
- ☐ Flush venous access with 0.9% NaCl 3-10 mL before and after med administration, as appropriate

☐ Verify completion of pre-labs prior to infusion (provider to place orders with lab separately):
- ☐ Blood glucose (non-fasting) – Hold infusion & notify provider if glucose is <70 or >250
- ☐ HCG serum/urine pregnancy test – Hold infusion & notify provider if positive pregnancy test

☐ Stop infusion and notify provider if hypersensitivity or infusion-related reaction develops
☐ Educate patient on s/s of reaction and monitor patient for at least 90 minutes post infusion
☐ Other: _____

PRESCRIBING PHYSICIANS SIGNATURE	NPI	DATE
_____	_____	_____

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.