Allied HEALTH SOLUTIONS
HOME INFUSION
An affiliate of WVUMedicine

Tepezza
IV INFUSION
PATIENT REFERRAL FORM

Referral Fax: (304) 244-7001
Referral Email: allied@homeinfusion.com
Phone: (304) 974-3340
If external referral (patient outside WVU Medicine), also attach a copy of patient demographics, insurance information, & pertinent clinical notes/labs.

PROVIDER:		OFFICE CONTACT:	
OFFICE/ADDRESS:		PHONE:	FAX:

PATIENT INFORMATION

NAME:		DOB:	SEX: ☐M ☐F
MRN:	PHONE:	ALLERGIES:	
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:_____		Face-to-Face Completed: ☐ Yes ☐No Office visit date: _____ Freedom of Choice discussed w/ Patient: ☐ Yes ☐ No	HT: _____ ☐cm ☐in WT used to calculate dose: _____ ☐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 ____ mg ORAL once 30-60 minutes prior to infusion ☐diphenhydramine ____ mg (☐ORAL **or** ☐IV) once 30-60 minutes prior to infusion ☐hydrocortisone ____ mg IV push once 30 mins prior to infusion ☐methylprednisolone ____ mg IV once 30 minutes prior to infusion ☐other: _____	☐epinephrine ____ mg IM once; may be repeated every 5-15 minutes, if needed, for up to 3 total doses ☐diphenhydramine ____ mg (☐ORAL **or** ☐IV) once if needed ☐hydrocortisone ____ mg IV push once if needed ☐methylprednisolone ____ mg IV push once if needed ☐acetaminophen ____ 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 should 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
- ☐ Administer infusion per manufacturer guidelines

NURSING ORDERS

☐ Infusion nurse visits to administer medication and assess & educate patient
☐ Infusion nurse to start and remove peripheral IV access
☐ Line care and flushing per AHS Home Infusion standing orders and nursing agency policy and procedure
☐ Verify completion of pre-labs prior to infusion *(provider to place separate orders with lab)*:
- ☐ 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 if hypersensitivity or infusion-related reaction develops, follow provider's EMERGENCY MEDICATION orders and nursing agency policy and procedure for anaphylactic /adverse reaction, and notify provider.
☐ Educate patient on s/s of reaction and monitor patient for at least ____ minutes post infusion for any reactions
☐ Other (if applicable): _____

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.