

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: <input type="checkbox"/> M <input type="checkbox"/> F
MRN:	PHONE:	ALLERGIES:	
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: _____		Face-to-Face Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No Office visit date: _____ Freedom of Choice discussed w/ Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No	HT: _____ <input type="checkbox"/> cm <input type="checkbox"/> in WT used to calculate dose: _____ <input type="checkbox"/> kg <input type="checkbox"/> lb
EMERGENCY CONTACT:			PHONE:
PRE-MEDICATIONS		PRN / EMERGENCY MEDICATIONS	
<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 _____ mg ORAL once 30-60 minutes prior to infusion <input type="checkbox"/> diphenhydramine _____ mg (____ ORAL or ____ IV) once 30-60 minutes prior to infusion <input type="checkbox"/> hydrocortisone _____ mg IV push once 30 mins prior to infusion <input type="checkbox"/> methylprednisolone _____ mg IV once 30 minutes prior to infusion <input type="checkbox"/> other: _____		<input type="checkbox"/> epinephrine _____ mg IM once; may be repeated every 5-15 minutes, if needed, for up to 3 total doses <input type="checkbox"/> diphenhydramine _____ mg (____ ORAL or ____ IV) once if needed <input type="checkbox"/> hydrocortisone _____ mg IV push once if needed <input type="checkbox"/> methylprednisolone _____ mg IV push once if needed <input type="checkbox"/> acetaminophen _____ mg ORAL once if needed <input type="checkbox"/> other / per provider protocol (specify & attach): _____	
INFUSION THERAPY			
<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 should 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"/> Administer infusion per manufacturer guidelines			
NURSING ORDERS			
<input type="checkbox"/> Infusion nurse visits to administer medication and assess & educate patient <input type="checkbox"/> Infusion nurse to start and remove peripheral IV access <input type="checkbox"/> Line care and flushing per AHS Home Infusion standing orders and nursing agency policy and procedure <input type="checkbox"/> Verify completion of pre-labs prior to infusion (<i>provider to place separate orders with lab</i>): <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 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. <input type="checkbox"/> Educate patient on s/s of reaction and monitor patient for at least _____ minutes post infusion for any reactions <input type="checkbox"/> 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.		_____	_____

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