Specialty Infusion Apothecary & Wellness Spa

INFUSION ORDERS-TEPEZZA (TEPROTUMUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS		
☐ New Referral	☐ Dose or Frequency Change	☐ Order Renewal

DIAGNOSIS AND ICD 10 CODE

☐ Thyroid Eye Disease	ICD 10 Code: E05.00
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes supporting primary diagnosis
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis

MEDICATION ORDERS
Initial IV dose: ☐ Tepezza 10mg/kg IV once, initial dose Maintenance Dosing (will start 3 weeks after initial dose, when applicable): ☐ Tepezza 20mg/kg IV every 3 weeks x 7 doses Other (please include dose, route, frequency, and number of refills): ☐ Tepezza _____ PLEASE NOTE: First and second doses will be administered over 90 minutes, and if tolerated, subsequent doses will be administered over 60 minutes.
Patient weight (kg): _____

PHYSICIAN INFORMATION		
Prescribing Physician:		
Office Phone:	Office Fax:	Office Email:
Physician Signature:		Date:

Contact us with questions at: info@siainfusions.com or call (561) 955-7079

Fax completed form and all documentation to **(561) 617-5360**

All information contained in this form is strictly confidential and will become part of the patient's medical record.