INTRAMED Plus
infusion services

TEPEZZA®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ Thyroid Eye Disease (TED) ICD-10 Code: E05.00 _____

_____ Other:_____ ICD-10 Code: _____

Allergies:_____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
  - Recent Lab Results including A1C to reflect baseline glycemic control
- Negative pregnancy test results within 48 hrs prior to Tepezza infusion

Patient
Weight: _____ lbs.
Height: _____ in.

TEPEZZA® (Teprotumumab-trbw) J Code: J3241

4. Drug Order:

❑ First Infusion
Administer Tepezza 10 mg/kg IV (_____ mg) over 90 minutes

❑ Subsequent Infusions # Refills _____(Maximum of 7 Infusions)
Administer Tepezza 20 mg/kg IV (_____ mg) over 60 - 90 minutes every three weeks

Pre-Medication Orders: _____
No pre-medications are recommended based on manufacturer guidelines.

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

FAX ALL INFORMATION **CENTRAL FAX 803.999.1754**	**INFUSION CENTER LOCATIONS** **BERKELEY CHARLESTON COLUMBIA GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**