

# Tepezza Order Form



Phone/Fax: 888-360-2455  
 360medicalbilling@curbsideinfusion.com or referrals@curbsideinfusion.com

Patient Information			
Patient Name:	DOB:	Phone:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Patient Address:	Email:	Insurance:	

Additional Information Needed		
<input type="checkbox"/> Fax front/back of insurance card	<input type="checkbox"/> Fax clinical/progress notes	<input type="checkbox"/> Fax labs
<input type="checkbox"/> Fax patient demographics	<input type="checkbox"/> Fax current medication list	<input type="checkbox"/> Fax TB and Hep B results

### Diagnosis and Clinical Information

**Diagnosis (ICD-10):**  
 E05.00 Thyrotoxicosis with Diffuse Goiter without Thyrotoxic Crisis or Storm (Hyperthyroidism)  
 Other: Code: \_\_\_\_\_ Description: \_\_\_\_\_

**Clinical Information:**  
 New Therapy Induction     Therapy Change     Therapy Continuation  
 Patient Weight: \_\_\_\_\_ lbs / \_\_\_\_\_ kg     Patient Height: \_\_\_\_\_ in / \_\_\_\_\_ cm  
 Allergies: \_\_\_\_\_  
 Therapies Tried and Failed: \_\_\_\_\_  
 TB Test: Date: \_\_\_\_\_ Results: \_\_\_\_\_     Hep B Test: Date: \_\_\_\_\_ Results: \_\_\_\_\_  
 Does patient have documented Thyroid Eye Disease (TED)?     Yes     No    *(If "No," patient is not a candidate for Tepezza)*

Lab Orders	Lab Orders to be done by
<input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> HBsAg <input type="checkbox"/> HBsAB <input type="checkbox"/> HBcAB <input type="checkbox"/> Quantiferon Gold <input type="checkbox"/> T3 <input type="checkbox"/> T4 <input type="checkbox"/> TSH <input type="checkbox"/> Other: _____	<input type="checkbox"/> Oklahoma Infusion Services <input type="checkbox"/> Referring Provider

**Prescription Information**

<input type="checkbox"/> Tepezza	<input type="checkbox"/> Initial Dose: 10mg/kg week 0 <input type="checkbox"/> Maintenance Dose: 20mg/kg every 3 weeks after week 0 for 7 additional infusions
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**Pre-Medication Orders**

<input type="checkbox"/> Solu-Cortef 50-100mg SIVP	<input type="checkbox"/> Benadryl 25mg PO PRN	Quzyttir 10mg IVSP over 1-2 min
<input checked="" type="checkbox"/> Tylenol tablet 500-1000mg PO PRN	<input type="checkbox"/> Other: _____	

**Standing Orders for Adverse Reactions**

<input checked="" type="checkbox"/> Stop infusion and initiate NS bolus	<input checked="" type="checkbox"/> Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis
<input checked="" type="checkbox"/> Notify supervising physician and ordering provider	<input checked="" type="checkbox"/> Oxygen 2-5L nasal cannula
<input checked="" type="checkbox"/> Solu-Cortef 100mg SIVP signs of adverse reaction	<input checked="" type="checkbox"/> Albuterol 2.5mg inhaled PRN for chest tightness
<input checked="" type="checkbox"/> Benadryl 25mg SIVP for hives or bronchial inflammation	<input type="checkbox"/> Other: _____

**Prescriber Information**

Prescriber Name:	Office Contact Name:		
NPI #:	DEA #:	Contact Phone:	Contact Fax:

\_\_\_\_\_  
 Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*By signing this form, you are authorizing Curbside Infusion Venture LLC and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.*