Tepezza Order Form

CURBSIDE INFUSION SERVICES

Phone/Fax: 713-489-9955
360medicalbilling@curbsideinfusion.com or referrals@curbsideinfusion.com

Patient Information

Patient Name:	DOB:	Phone:	Gender: M ☐ F ☐
Patient Address:	Email:	Insurance:	

Additional Information Needed

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ 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

☐ CBC ☐ CMP ☐ HBsAg ☐ HBsAB ☐ HBcAB ☐ Quantiferon Gold ☐ T3 ☐ T4 ☐ TSH
☐ Other: _____

Lab Orders to be done by

☐ Oklahoma Infusion Services
☐ Referring Provider

Prescription Information

☐ Tepezza
☐ Initial Dose: 10mg/kg week 0
☐ Maintenance Dose: 20mg/kg every 3 weeks after week 0 for 7 additional infusions

Pre-Medication Orders

☐ Solu-Cortef 50-100mg SIVP ☐ Benadryl 25mg PO PRN ☐ Quzyttir 10mg IVSP over 1-2 min
☐ Tylenol tablet 500-1000mg PO PRN ☐ Other: _____

Standing Orders for Adverse Reactions

☐ Stop infusion and initiate NS bolus ☐ Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis
☐ Notify supervising physician and ordering provider ☐ Oxygen 2-5L nasal cannula
☐ Solu-Cortef 100mg SIVP signs of adverse reaction ☐ Albuterol 2.5mg inhaled PRN for chest tightness
☐ Benadryl 25mg SIVP for hives or bronchial inflammation ☐ 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.