



Tepezza Order Form

Tele: (877) 246-9104
Fax: (800) 783-9146

WWW.Biotekrx.com

PATIENT INFORMATION		PHYSICIAN INFORMATION	
Patient Name: _____		Name: _____	
Address: _____		Specialty: _____	
City, State, Zip: _____		DEA: _____ NPI: _____	
Phone: _____ Alt Phone: _____		Address: _____	
DOB: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		City, State, Zip: _____	
Weight: _____ kg		Phone: _____ Fax: _____	
INSURANCE INFORMATION: Please copy and attach the front and back of insurance and prescription card			
Primary Insurance: _____		RX Card (PBM): _____	
City, State, Zip: _____		BIN: _____ PCN: _____	
Member ID#: _____ Phone: _____		City, State, Zip: _____	
Plan#: _____ Group#: _____		Plan#: _____ Group#: _____	
DIAGNOSIS / CLINICAL INFORMATION			
Primary Diagnosis:			
<input type="checkbox"/> E05.00 Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm (hyperthyroidism)			
<input type="checkbox"/> Other: _____			
Additional disease manifestation codes: _____			
List of patient's current medication(s): _____			
Allergies: _____			
Does the patient have documented Thyroid Eye Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does the patient have a history of IBD? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does the patient have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No			
* Patients with preexisting diabetes should be under appropriate glycemic control before receiving Tepezza.			
PRESCRIPTION / ADMINISTRATION			
Medication: Tepezza for injection for intravenous use // 500mg vial			
Duration: 1 infusion every 3 weeks for a total of 8 infusions. Administer the first 2 infusions over 90 minutes. Subsequent infusions may be reduced to 60 minutes if well tolerated.			
Dose: Week 0: _____ mg (10 mg/kg) – 21 day supply; 1 prescription; no refill Week 3: _____ mg (20 mg/kg) – 21 day supply; 1 prescription; 6 refills; q3wk			
Fluid administration: Reconstitute each vial with 10mL of sterile water for injection, USP. Administer via an infusion bag containing 0.9% Sodium Chloride Solution, USP. For doses <1800mg, use a 100mL bag. For doses ≥1800mg, use a 250mL bag.			
Anaphylaxis			
<input type="checkbox"/> Diphenhydramine 50 mg IV push - Administer over at least 2 minutes as needed for mild to moderate infusion reaction.			
<input type="checkbox"/> Solu-Medrol 125 mg IV push - Administer over 3-5 minutes as needed for moderate to severe infusion reaction.			
<input type="checkbox"/> Epinephrine 0.3 mg (0.3 ml) - For adults over 30 kg - Administer 0.3 mg by intramuscular injection as needed for signs / symptoms of anaphylaxis. May repeat dose after 5-10 minutes if necessary.			
<input type="checkbox"/> Other: _____			
SIGNATURE			
X: _____		Date: _____	
Product Substitution Permitted			

CONFIDENTIALITY STATEMENT: This facsimile and documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited.

If you have received this information in error, please notify the sender at the address and telephone number set forth herein and arrange for return or destruction of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee. Fax completed form to: (800) 783-9146 - Thank you for using BioTek reMEDys@.