TwelveStone Health Partners
Fax Referral To:
(800) 223-4063
Direct Phone: (615) 278-3350
Toll Free: (844) 893-0012

TEPEZZA ORDER FORM

Date: _____

Patient Name: _____

Date of Birth: _____

ICD-10 Code: _____

Allergies: _____

Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

Provider Information

Ordering Provider: _____

Provider NPI: _____

Provider Phone: _____

Provider Fax: _____

Provider Address: _____

MEDICATION ORDER

Tepezza	✓ Administer Tepezza 10mg/kg IV x one dose per protocol. ✓ Administer Tepezza 20mg/kg IV x 7 doses every three weeks, starting three weeks after initial 10mg/kg dose per protocol. ✓ First two doses to be administered over 90 minutes. If well tolerated, subsequent doses may be administered over 60 minutes.	Refills x one year from date of signature unless indicated below. ☐ _____ Refills	***Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:*** ✓ Hgb A1C within the past six months (if patient is diabetic). If patient is not diabetic, baseline Hgb A1C will be drawn with first infusion. ✓ Baseline blood glucose within the past 60 days for non-diabetic patients.

PRE-MEDICATIONS

Oral

- ☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg
- ☐ Loratadine: 10mg
- ☐ Cetirizine: 10mg
- ☐ Diphenhydramine: ☐ 25mg ☐ 50mg
- ☐ Famotidine: ☐ 20mg ☐ 40mg
- ☐ Ibuprofen: ☐ 200mg ☐ 400mg ☐ 600mg
- ☐ Ondansetron: ☐ 4mg ☐ 8mg
- ☐ Other: _____

IV

- ☐ Dexamethasone: ☐ 4mg ☐ 8mg
- ☐ Diphenhydramine: ☐ 25mg ☐ 50mg
- ☐ Famotidine: ☐ 20mg ☐ 40mg
- ☐ Methylprednisolone: 125mg
- ☐ Hydrocortisone: 100mg
- ☐ Ondansetron: ☐ 4mg ☐ 8mg
- ☐ Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written:

_____ _____
Prescriber Name Date

Substitution Allowed:

_____ _____
Prescriber Name Date