TwelveStone Health Partners

Fax Referral To: (800) 223-4063

Email: intake@12stonehealth.com

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

TEPEZZA ORDER FORM

Date: _____ ICD-10 Code: _____

Patient Name: _____ Allergies: _____

Date of Birth: _____ Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ Provider Address: _____

Provider Phone: _____

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.

✓ Baseline hearing assessment has been performed by prescriber and will be evaluated periodically by prescriber during and after completion of treatment.

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

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

(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