

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: referral@12stonehealth.com



TEPEZZA ORDER FORM

Patient Name: _____ ICD-10 Code: _____ Date of Birth: _____ Allergies: _____ Weight: _____ lbs OR _____ kg	Therapy Status <input type="checkbox"/> New Start <input type="checkbox"/> Continuing Therapy: Last Dose: _____
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PROVIDER INFORMATION

Ordering Provider: _____	Provider Fax: _____
Provider NPI: _____	Provider Address: _____
Provider Phone: _____	

MEDICATION ORDER

Tepezza	<ul style="list-style-type: none"> ✓ 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. 	<p>Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</p> <ul style="list-style-type: none"> ✓ 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
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PRE-MEDICATIONS

Oral <input type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: 10mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____	IV <input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Methylprednisolone: 125mg <input type="checkbox"/> Hydrocortisone: 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____
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LAB ORDERS (please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

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) <ul style="list-style-type: none"> • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work
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By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

_____ Prescriber Signature	_____ Date
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