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

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ Provider Address: _____

Provider Phone: _____

MEDICATION ORDER

Tepezza

Please check this box if the baseline hearing assessment has been performed.

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

This is a mandatory requirement before we can initiate therapy.

✓ 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.

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 615-278-3355)

- 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)*

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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