Cumberland Vital Care

Fax Referral To: (931) 456-4857

Direct Phone: (615) 278-3350

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 Ofice 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

The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intended recipient, please notify us immediately by calling 615-895-0186 or faxing back to the originator.