## **Cumberland Vital Care** Fax Referral To: (931) 456-4857

Direct Phone: (615) 278-3350



* Administer Tepezza       * Administer Tepezza 20mg/kg IV x 7 doses every three weeks, starting three weeks after initial 10mg/kg dose per protocol.       * First works, 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.       * Hgb A1C within the past six months (if patient is diabetic). If patien to diabetic, baseline Hgb A1C will be drawn with first infusion         * Baseline hearing assessment has been performed by prescriber and will be evaluated periodically by prescriber and will be evaluated periodically by prescriber and will be evaluated periodically by prescriber during and after completion of treatment.       * Mgb A1C within the past 60 days for non-diabetic patients         Oral       Catataline: 10mg       Dexamethasone:4rmg8mg         Cetirizine: 10mg       Diphenhydramine:25mg50mg       Diphenhydramine:25mg50mg         Graid       Yere and diabetic any labs to be drawn and frequency)       Methylpredisione: 125mg         LAB ORDERS (please indicate any labs to be drawn and frequency)       * (Please fax this signed order form, along with the following documen to 800-223-4063)         * History & Physical, Last Ofice Visit Note       * Patient Demographics and Insurance Information         **Surveillance lab ordering and monitoring is the responsibility of the prescriber*       * Rescrit Lab Work	TEPEZZA ORDER FORM				
Patient Name:	Date: ICD-10 Code:				
Ordering       Vegint       Last Dose:         PROVIDER INFORMATION         Ordering Provider:       Provider Ner(	Patient Name:	Allergies:		New Start	
PROVIDER INFORMATION         Ordering Provider.       Provider Fax:	Date of Birth:Ibs OR		kg	Continuing Therapy: Last Dose:	
Provider NPI:					
MEDICATION ORDER         MEDICATION ORDER <ul> <li>Administer Tepezza 10mg/kg IV x one dose per protocol.</li> <li>Administer Tepezza 20mg/kg IV x 7 doses every three weeks, starting three weeks after initial 10mg/kg dose per protocol.</li> <li>Administer Tepezza 20mg/kg IV x 7 doses every three weeks after initial 10mg/kg dose per protocol.</li> <li>First two doses to be administered over 90 minutes. If well tolerated, subsequent doses may be administered over 60 minutes.</li> <li>Baseline hearing assessment has been performed by presoriber and will be evaluated periodically by presoriber and wills de valuated periodically by presoriber during and atter completin of treatment.</li></ul>	Ordering Provider: Provider Fax:				
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Oral       Acetaminophen:325mg500mg650mg       //         Loratadine: 10mg       Diphenhydramine:25mg50mg       Biphenhydramine:20mg40mg         Diphenhydramine:20mg40mg       Methylprednisolone: 125mg         Hydrocortisone: 100mg       Methylprednisolone: 125mg         Ondansetron:4mg8mg       Ondansetron:4mg8mg         Other:       Other:         UAB ORDERS (please indicate any labs to be drawn and frequency)       (Please fax this signed order form, along with the following documento 800-223-4063)         **Surveillance lab ordering and monitoring is the responsibility of the prescriber**       Patient Demographics and Insurance Information         **Surveillance lab ordering and monitoring is the responsibility of the prescriber**       Recent Lab Work         By signing below, I certify that the above therapy is medically necessary.       Prescriber's Signature (SIGN BELOW)	<ul> <li>Administer Tepezza 20mg/kg IV x 7 doses every three weeks, starting three weeks after initial 10mg/kg dose per protocol.</li> <li>First two doses to be administered over 90 minutes. If well tolerated, subsequent doses may be administered over 60 minutes.</li> <li>Baseline hearing assessment has been performed by prescriber and will be evaluated periodically by</li> </ul>		<ul> <li><i>prior to first infusion:</i></li> <li>✓ 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</li> <li>✓ Baseline blood glucose within the past 60 days for non-diabetic</li> </ul>		
Acetaminophen:       325mg       500mg       650mg         Loratadine: 10mg       Diphenhydramine:       25mg       50mg         Diphenhydramine:       25mg       50mg       Famotidine:       20mg       40mg         Diphenhydramine:       20mg       40mg       Methylprednisolone: 125mg       Hydrocortisone: 100mg         Ibuprofen:       200mg       400mg       600mg       Ondansetron:       4mg       8mg         Ondansetron:       4mg       8mg       Other:       4mg       8mg         LAB ORDERS (please indicate any labs to be drawn and frequency)       (Please fax this signed order form, along with the following documen to 800-223-4063)       History & Physical, Last Ofice Visit Note         **Surveillance lab ordering and monitoring is the responsibility of the prescriber**       Recent Lab Work       Recent Lab Work	PRE-MEDICATIONS				
<ul> <li>(Please fax this signed order form, along with the following document to 800-223-4063)</li> <li>History &amp; Physical, Last Ofice Visit Note</li> <li>Patient Demographics and Insurance Information</li> <li>Medication List</li> <li>Recent Lab Work</li> </ul> By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)	<ul> <li>Acetaminophen:325mg500mg650mg</li> <li>Loratadine: 10mg</li> <li>Cetirizine: 10mg</li> <li>Diphenhydramine:25mg50mg</li> <li>Famotidine:20mg40mg</li> <li>Ibuprofen:200mg400mg600mg</li> </ul>			henhydramine:25mg50mg notidine:20mg40mg thylprednisolone: 125mg drocortisone: 100mg dansetron:4mg8mg	
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Dispense as vvritten: Substitution Allowed:			<ul> <li>History &amp; Physical, Last Ofice Visit Note</li> <li>Patient Demographics and Insurance Information</li> <li>Medication List</li> <li>Recent Lab Work</li> </ul>		
Prescriber Name       Date       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       Date					

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