Fax Form to: 330-294-2082

INDY INFUSION

TEPEZZA REFERRAL FORM

REFERRAL STATUS: ___New Referral ___Updated Order ___Order Renewal

PATIENT DEMOGRAPHICS:

PATIENT NAME:	PATIENT'S CONTACT #:
DATE OF REFERRAL:	ADDRESS:
DATE OF BIRTH:	CITY, STATE, ZIP:
FOR COPAY ASSISTANCE, PLEASE PROVIDE LAST 4 OF SSN:	
HEIGHT: _____ FEET _____ INCHES	GENDER: FEMALE ☐ MALE ☐
WEIGHT: _____ LB or _____ KG	ALLERGIES: SEE LIST ☐ NKDA ☐

PRIMARY DIAGNOSIS:

ICD-10 CODE: ☐ E05.00 - Thyrotoxicosis with Diffuse Goiter without Thyrotoxic Crisis or Storm ☐ Other

REQUIRED DOCUMENTATION: Please provide a copy of the following documents.

☑ 1. INSURANCE CARD (Front & Back) ☑ 2. PATIENT DEMOGRAPHICS ☑ 3. MOST RECENT LABS ☑ 4. MEDICATION LIST

☑ 5. H & P ☑ 6. CAS OF 4 OR GREATER ☑ 7. THYROID LABS ☑ 8. PREGNANCY TEST

☑ Does patient have an endocrinologist: ☐ Y ☐ N If so, please list name:

PRIMARY MEDICATION/ LAB ORDERS:

****PATIENTS WITH PRE-EXISTING DIABETES SHOULD BE UNDER APPROPIATE GLYCEMIC CONTROL BEFORE RECEIVING TEPEZZA.*

☐ Infusion 1: Tepezza 10 mg/kg IV to be followed 3 weeks later by Infusions 2-8: Tepezza 20 mg/kg every 3 weeks for seven doses

☐ Other: _____

☐ Blood Glucose Test every _____ infusion ☐ HgA1C every _____ infusion

FIRST DOSE: ☐ Y ☐ N

☑ Refill x12 months unless otherwise noted.

PRN & PREMEDICATIONS:

MEDICATIONS	30 minutes prior to every infusion	PRN
Acetaminophen 650 mg PO	☐	PRN every ___ hour for mild or moderate infusion reaction.
Diphenhydramine 25 mg PO	☐	PRN every ___ hour for mild or moderate infusion reaction.
Diphenhydramine 25 mg IV	☐	PRN every ___ hour for mild or moderate infusion reaction.
Methylprednisolone 125 mg IV	☐	PRN every ___ hour for mild or moderate infusion reaction.
Other: _____	☐	PRN every ___ hour for mild or moderate infusion reaction.

LINE USE/CARE ORDERS:

☑ START PIV/ACCESS CVC

☑ FLUSH DEVICE PER FLEXCARE INFUSION POLICY & PROCEDURE (SEE REVERSE SIDE)

☐ OTHER FLUSH ORDERS: (please fax other reaction orders if checking this box)

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

☑ ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER FLEXCARE INFUSION POLICY AND PROCEDURE (See Reverse Side)

☐ OTHER: (please fax other reaction orders if checking this box)

PRESCRIBER INFORMATION: Please check preferred form of communication.

PHYSICIAN NAME:	PHONE:
OFFICE CONTACT:	☐ FAX:
ADDRESS:	☐ EMAIL:
CITY, STATE, ZIP:	NPI:

→ (GENERIC SUBSTITUTION PERMITTED)

PHYSICIAN SIGNATURE: DATE:

→ (DISPENSE AS WRITTEN)

PHYSICIAN SIGNATURE: DATE:

Indy Infusion is a product of Independence Visiting Primary Care