MIC | METRO INFUSION CENTER

# INFUSION ORDERS-TEPEZZA (TEPROTUMUMAB-TRBW)

| PATIENT INFORMATION | |
|---|---|
| Name: | DOB: |
| Allergies: | Date of Referral: |

| REFERRAL STATUS |
|---|
| ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal |

| INFUSION OFFICE PREFERENCES (Optional) |
|---|
| Preferred Location*: |

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/
Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

| DIAGNOSIS AND ICD 10 CODE | |
|---|---|
| ☐ Thyroid Eye Disease | ICD 10 Code: E05.00 |
| ☐ Other: _____ | ICD 10 Code: _____ |

| REQUIRED DOCUMENTATION | |
|---|---|
| ☐ This signed order form by the provider | ☐ Clinical/Progress notes supporting primary diagnosis |
| ☐ Patient demographics AND insurance information | ☐ Labs and Tests supporting primary diagnosis |

| MEDICATION ORDERS |
|---|
| Initial IV dose:<br>☐ Tepezza 10mg/kg IV once, initial dose<br><br>Maintenance Dosing (will start 3 weeks after initial dose, when applicable):<br>☐ Tepezza 20mg/kg IV every 3 weeks x 7 doses<br><br>Other (please include dose, route, frequency, and number of refills):<br>☐ Tepezza _____<br><br>PLEASE NOTE: First and second doses will be administered over 90 minutes, and if tolerated, subsequent doses will be administered over 60 minutes. |
| Patient weight (kg): _____ |

| PHYSICIAN INFORMATION | | |
|---|---|---|
| Prescribing Physician: | | |
| Office Phone: | Office Fax: | Office Email: |
| Physician Signature: | | Date: |

**All information contained in this order form is strictly confidential and will become part of the patient's medical record.**
**Contact us with questions at: (877) 448-3627**
**Fax Completed Form and all documentation to: (866) 507-1164**