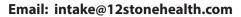
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





TEPEZZA ORDER FORM							
Date:		ICD-10 Code:				Therapy Status	
Patient Name:		Allergies:				☐ New Start	
Date of Birth:		Weight:Ik	os OR	k	g	☐ Continuing Therapy: Last Dose:	
PROVIDER INFORMATION							
Ordering Provider:P					ıx:		
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. Tepezza ✓ First two doses to be administered over 90 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			
	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.						
PRE-MEDICATIONS							
Oral □ Acetaminophen:325mg500mg650mg □ Loratadine: 10mg □ Cetirizine: 10mg □ Diphenhydramine: 25mg 50mg □ Famotidine: 20mg 40mg □ Ibuprofen: 200mg 400mg 600mg □ Ondansetron: 4mg 8mg			<u>IV</u>	Diphe Famo Methy Hydro Onda	methasone:4mg enhydramine:25mg_ tidine:20mg ylprednisolone: 125mg ocortisone: 100mg nsetron:4mg	50mg 40mg _8mg	
LAB ORDERS (please indicate any labs to be drawn and frequency)				OTH	IER REQUIRED DOC	UMENTATION	
Surveillance lab ordering and monitoring is the responsibility of the prescriber By signing below, I certify that the above therapy is medi			(Please fax this signed order form, along with the following documents to 800-223-4063) • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work cally 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.							
Dispense as Written:			Substitut				
Prescriber Na	ame	Date		Prescrib	er Nam	ne	Date