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TEPEZZA (TEPROTUMUMAB-TRBW) INFUSION ORDERS

****REQUIRED INFORMATION****

- ☐ This signed order form from the provider
- ☐ Patient demographics & insurance information
- ☐ **Clinical/Progress Notes** supporting primary diagnosis
- ☐ Most Recent Lab Results

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis:

☐ Thyroid Eye Disease (ICD-10: ________________)

__________________ (ICD-10:___________________)

TEPEZZA ORDERS

10mg/kg IV as a single dose, followed by 20mg/kg every 3 weeks for 7 additional doses   Patient Wt.____________kg

Other:____

****Once we receive all necessary documentation, we will schedule the patient's treatment.**

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**NPI:**	**Date:**