REVITALIZE
INFUSION CENTER

Tepezza®

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis:

☐ Thyroid Eye Disease ICD-10 Code: E05.00

☐ Other_____ ICD-10 Code_____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Active Medication List
- Relevant labs and tests
- Required Information:
  - Recent labs including A1C
  - Negative Pregnancy Test 48 Hours Prior to Infusion (if applicable)
  - Baseline hearing exam PRN

Height: _____

Weight: _____

Tepezza® (teprotumumab-trbw) Orders:

☐ **First Infusion**

Administer Tepezza 10 mg/kg intravenously (_____ mg) over 90 minutes

☐ **Subsequent Infusions**

Administer Tepezza 20 mg/kg intravenously (_____ mg) over 60- 90 minutes every three weeks for 7 additional infusions

Pre-Medication Orders:_____

*No pre-medications are recommended based on the manufacturer's PI

Lab Orders:_____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

Please fax the completed order form an all other requested information to: 601-714-1569

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus