



Tepezza Order Form

Select patient referral location: Blue Ash Worthington Crestview Hills Springfield West Cincinnati
Fax completed form to 888-977-0914. For new referrals, please include recent labs and last two office visit notes.

Toll Free Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> Lbs <input type="checkbox"/> Kg
Patient Status: <input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy <input type="checkbox"/> Next due date (if applicable):	

2. PHYSICIAN INFORMATION

Physician's name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:	State:	Zip:
Office contact:	Email:	
Office phone:	Office fax:	

3. DIAGNOSIS INFORMATION (and year of diagnosis)

Thyroid Eye Disease (_____) ICD 10 (_____) Other (specify): _____

4. INSURANCE INFORMATION

Please submit copies of the front and back of primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION (requires new order every 12 months)

TEPEZZA <input type="checkbox"/> Initial <input type="checkbox"/> Maintenance	PRE-MEDICATIONS <input type="checkbox"/> N/A
<input type="checkbox"/> Initial Dose: Administer _____mg at 10mg/kg at week 0	<input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg PO
<input type="checkbox"/> Maintenance Dose: Administer q 3 weeks: _____mg at 20mg/kg x 7 infusions	<input type="checkbox"/> Fexofenadine (Allegra) 180mg PO (or other non-sedating anti-histamine)
<input type="checkbox"/> Vital signs per HI protocol	<input type="checkbox"/> Diphenhydramine (Benadryl) <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> PO <input type="checkbox"/> IV (requires driver)
<input type="checkbox"/> Anaphylaxis & hydration management per HI protocol	<input type="checkbox"/> Methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg <input type="checkbox"/> 80mg <input type="checkbox"/> 125mg IV
	<input type="checkbox"/> Prednisone _____mg PO
	<input type="checkbox"/> Other: _____
	POST-MEDICATIONS <input type="checkbox"/> N/A
	<input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg PO
	<input type="checkbox"/> Prednisone _____mg PO
	<input type="checkbox"/> Other: _____

6. LABS

<input type="checkbox"/> CBC w/Diff	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> CRP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> CMP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> ESR	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Hepatic Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Renal Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Quantiferon TB Gold, annually, last completed (date): _____		
<input type="checkbox"/> Other (specify): _____		

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE