



Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)				PRESCRIBER INFORMATION		
Name: DOB:				Prescriber Name:		
Address:				State License:		
City, State, Zip:			NPI #: Tax ID:			
Phone: Alt. Phone:				Address:		
Email: SS#:						
Gender: \square M \square F Weight:(lbs) Ht:				Phone: Fax:		
Allergies:				Office Contact: Phone:		
INSURANCE INFORM	NOITAN	– AND – Send a copy of the	e patie	nt's prescription/ins	urance cards (front & back)	
Primary Insurance:				Secondary Insurance (If Applicable):		
Plan #:						
Group #:						
RX Card (PBM):						
		PCN:			PCN:	
CLINICAL INFORMA	TION					
☐ E05.00 Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm (hyperthyroidism) ☐ Other ICD-10:						
Does the patient have documented Thyroid Eye Disease? Yes No If yes, date of diagnosis:						
Does the patient have a history of IBD?						
ORDERS						
Prescription type: New start Restart Continued therapy Total Doses Received: Date of Last Injectio					Date of Last Injection/Infusion	:
Medication				e/Frequency		Refills
☐ Tepezza® (teprotumumab-trbw)	☐ Initial dose: 10 mg/kg (mg) IV x 1 dose					
		☐ Maintenance: 20 mg/kg (mg) IV every 3 weeks x 7 doses, beginning 3 weeks after initial dose				
	□ Other:					
	☐ Other		ng) IV eve		ginning 3 weeks after initial dose	
Pre-Medication			ng) IV eve		ginning 3 weeks after initial dose Directions	
Pre-Medication ☐ Acetaminophen		r:		ry 3 weeks x 7 doses, beg		
☐ Acetaminophen		Dose/Strength	☐ Take	ry 3 weeks x 7 doses, beg	Directions Infusion or post-infusion as directed	
		Dose/Strength	☐ Take	ery 3 weeks x 7 doses, beg	Directions Infusion or post-infusion as directed	
☐ Acetaminophen ☐ Diphenhydramine		Dose/Strength 500mg 25mg IV/PO	☐ Take	e 1-2 tablets PO prior to infu ct contents of 1 vial IV pri	Directions Infusion or post-infusion as directed sion or as directed OR	
☐ Acetaminophen		Dose/Strength 500mg 25mg IV/PO 50mg IV/PO	☐ Take	e 1-2 tablets PO prior to infu ct contents of 1 vial IV pri	Directions Infusion or post-infusion as directed Ission or as directed OR Isor to infusion or as directed Isor to infusion or as directed	
☐ Acetaminophen ☐ Diphenhydramine		Dose/Strength □ 500mg □ 25mg IV/PO □ 50mg IV/PO □ 40mg □ 100mg	☐ Take	e 1-2 tablets PO prior to infu to tablet PO prior to infu ct contents of 1 vial IV pri	Directions Infusion or post-infusion as directed Ission or as directed OR Isor to infusion or as directed Isor to infusion or as directed	
☐ Acetaminophen ☐ Diphenhydramine ☐ Methylprednisolone ☐		Dose/Strength 500mg 25mg IV/PO 50mg IV/PO 40mg 100mg 125mg	☐ Take	e 1-2 tablets PO prior to infu to tablet PO prior to infu ct contents of 1 vial IV pri	Directions Infusion or post-infusion as directed Ission or as directed OR Isor to infusion or as directed Isor to infusion or as directed	
□ Acetaminophen □ Diphenhydramine □ Methylprednisolone □ INFUSION REACTION		Dose/Strength 500mg 25mg IV/PO 50mg IV/PO 40mg 100mg 125mg	☐ Take	e 1-2 tablets PO prior to infu to tablet PO prior to infu ct contents of 1 vial IV pri	Directions Infusion or post-infusion as directed Ission or as directed OR Isor to infusion or as directed Isor to infusion or as directed	
☐ Acetaminophen ☐ Diphenhydramine ☐ Methylprednisolone ☐ INFUSION REACTION Mild reaction protocol:	N ORDE	Dose/Strength 500mg 25mg IV/PO 50mg IV/PO 40mg 100mg 125mg RS	☐ Take	e 1-2 tablets PO prior to infu to tablet PO prior to infu ct contents of 1 vial IV pri	Directions Infusion or post-infusion as directed Ission or as directed OR Isor to infusion or as directed Isor to infusion or as directed	
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□ Acetaminophen □ Diphenhydramine □ Methylprednisolone □ INFUSION REACTION Mild reaction protocol: ☑ Diphenhydramine 25n If symptoms worsen, see Moderate reaction protocol	N ORDE	Dose/Strength 500mg 25mg IV/PO 50mg IV/PO 40mg 100mg 125mg RS	☐ Take	e 1-2 tablets PO prior to infu to tablet PO prior to infu ct contents of 1 vial IV pri	Directions Infusion or post-infusion as directed Ission or as directed OR Isor to infusion or as directed Isor to infusion or as directed	
□ Acetaminophen □ Diphenhydramine □ Methylprednisolone □ INFUSION REACTION Mild reaction protocol: ☑ Diphenhydramine 25n If symptoms worsen, see Moderate reaction protocol ☑ Acetaminophen 650m	mg IV, one orders foocol:	Dose/Strength 500mg 25mg IV/PO 50mg IV/PO 40mg 100mg 125mg Etime, for pruritus. Trimoderate to severe reactions.	☐ Take	e 1-2 tablets PO prior to infu to tablet PO prior to infu ct contents of 1 vial IV pri	Directions Infusion or post-infusion as directed Ission or as directed OR Isor to infusion or as directed Isor to infusion or as directed	

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If symptoms worsen, see interventions for severe reactions Severe reaction protocol: (Call 911 if initiated): ☐ Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%) ☑ Diphenhydramine 50mg IV,one time, for respiratory symptoms, edema, or anaphylaxis Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis ☑ Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms ☑ Epinephrine 0.3mg/0.3mL IM into mis-anterolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen **FLUSHING & LOCKING ORDERS** Flushing Protocol (>66lbs/33kg) PIV and Midline: Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter: □ 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion ☑ 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw Locking Protocol (>66lbs/33kg) PIV and Midline: PICC: Implanted Port, Tunneled Catheter, and Nontunneled Catheter: □ Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush flush post normal saline flush ⋈ Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush ** May substitute Dextrose 5% in Water, or alternative, for 0.9& Sodium Chloride, when indicated due to incompatibility with medications bring infused **SIGNATURE** We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

Prescriber Signature

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