MPP INFUSION CENTERS
www.mppinfusion.com

**Fax Referrals To: (855) 891-2191**
**Email Referrals To: MPPReferral@mppinfusion.com**
**Have a Question? (855) 478-1528**

# TEPEZZA™(teprotumumab-trbw) ORDER FORM

*(* - Required Fields)*

☐ **STAT REQUEST**
**( *REASON MUST BE PROVIDED BELOW)**

☐ **New Referral** ☐ **Order Renewal** ☐ **Medication/Order Change**
☐ **Benefits Verification Only** ☐ **Discontinuation Order**

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| NAME*: | | DOB*: | SEX: ☐M ☐F |
| ADDRESS: | | PHONE: | |
| WEIGHT: ☐LBS ☐KG | HEIGHT: | EMAIL: | |
| ALLERGIES: | | | |

## PHYSICIAN INFORMATION

| | | |
|---|---|---|
| PHYSICIAN NAME*: | | PRACTICE NAME: |
| ADDRESS: | | OFFICE CONTACT*: |
| PHONE: | FAX: | EMAIL *(FOR UPDATES)*: |

## TEPEZZA ORDER*:

*(SELECT **ONE** OF THE FOLLOWING)*

**ICD-10*:** _____

Dosing: Infusion #1: 10mg/kg (second infusion 3 weeks after initial)

Infusion #2 to #8: 20mg/kg every 3 weeks

**Physician Signature*** _____ **Date*(Order is Valid for One Year)** _____
*Infusion will be administered per MPP policy and protocols*

## REQUIRED DIAGNOSIS:

☐ Thyroid Eye Disease

☐ Other_____

***STAT REASON:**
(STAT requests will be assessed per MPP policy and protocols)

**Last Infusion/Injection Date:** _____

## REQUIRED DOCUMENTATION CHECKLIST:

☐ Patient Demographics
☐ Insurance Card/Information
☐ Clinical/Progress Notes supporting DX
☐ Current Medication List and H&P
☐ A1C (if available)
☐ Clinical Activity Score (if available)
☐ Thyroid Panel with TSH (if available)

**STANDING LAB ORDERS:** ☐ CMP ☐ CBC

☐ Labs to be drawn by Infusion Center Frequency _____

***NOTES/ADDITIONAL COMMENTS:***

## Locations:

--------Colorado--------
☐ Lakewood

---------Florida---------
☐ Jacksonville
☐ Kissimmee
☐ Port St. Lucie
☐ Suncoast
☐ Winter Park

----------Texas----------
☐ Arlington
☐ Cedar Hill
☐ Dallas
☐ Denton
☐ Ft. Worth
☐ Irving
☐ Rockwall
☐ Southlake
☐ Flower Mound
☐ Plano
☐ Tyler

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