MIC | METRO INFUSION CENTER

INFUSION ORDERS-TEPEZZA (TEPROTUMUMAB-TRBW)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS		
☐ New Referral	☐ Dose or Frequency Change	☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/
Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE	
☐ Thyroid Eye Disease	ICD 10 Code: E05.00
☐ Other: ____	ICD 10 Code: _____________________

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes supporting primary diagnosis
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis

MEDICATION ORDERS

Initial IV dose:
☐ Tepezza 10mg/kg IV once, initial dose

Maintenance Dosing (will start 3 weeks after initial dose, when applicable):
☐ Tepezza 20mg/kg IV every 3 weeks x 7 doses

Other (please include dose, route, frequency, and number of refills):
☐ Tepezza ____

PLEASE NOTE: First and second doses will be administered over 90 minutes, and if tolerated, subsequent doses will be administered over 60 minutes.

Patient weight (kg): _______________

PHYSICIAN INFORMATION		
Prescribing Physician:		
Office Phone:	Office Fax:	Office Email:
Physician Signature:		Date:

Fax referral to (866) 507-1164 or email to MICreferral@metroinfusioncenter.com

All information contained in this form is strictly confidential and will become part of the patient's medical record.

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