Hy-Vee health INFUSION CARE

TEPEZZA
Infusion Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: _____ **DOB:** _____ **Phone:** _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

Medical Information

Diagnosis: ☐ Thyrotoxicosis w diffuse goiter without thyrotoxic crisis or storm **ICD-10 Code:** E05.00

☐ Other _____ **ICD-10 Code:** _____

Patient Weight: _____ lbs. (required) **Allergies:** _____

Therapy Order

Tepezza:

☐ 10 mg/kg IV for the first infusion, followed by 20 mg/kg IV (3 weeks after the initial dose) every 3 weeks for 7 additional infusions (8 total infusions)

Lab Orders: _____ **Lab Frequency:** _____

Required labs to be drawn by: ☐ Hy-Vee Health ☐ Referring Provider

Other Orders: _____

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50 mg orally OR IV (adult)
- Refer to physician order or institutional protocol for pediatric dosing

Flush orders: NS 1-20 mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

Provider Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ **Signature:** _____ **Date:** _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

☐ Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX

☐ Phoenix, AZ ☐ Other _____

HY-VEEHEALTHINFUSION.COM

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COMPREHENSIVE SUPPORT FOR TEPEZZA THERAPY

Patient Information

Patient Name: _____ **DOB:** _____

Required Documentation for Referral Processing & Insurance Approval

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's current medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits or contraindications to conventional therapy

- ☐ Has the patient had a documented contraindication/intolerance or failed trial of corticosteroids? ☐ Yes ☐ No
- ☐ Is the patient a current smoker? ☐ Yes ☐ No If yes, has smoking cessation been discussed? ☐ Yes ☐ No
- ☐ CAS score: _____ 0-10 scale **(required)**
- ☐ Indicate any symptoms the patient has:
  - ☐ Lid retraction ≥ 2mm ☐ Moderate or severe soft tissue involvement
  - ☐ Exophthalmos ≥ 3mm above normal for race and gender ☐ Diplopia
  - ☐ Other: _____

☐ Include labs and/or test results to support diagnosis

- ☐ TSH, T3, T4

☐ If history of diabetes, glucose is under control

☐ Has the patient had a course of Tepezza previously? ☐ Yes ☐ No

☐ **Other Medical Necessity:** _____

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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