

Rose Pharmacy
10008 Pines Blvd
Pembroke Pines, FL 33024
Phone: 954.432.8290
Fax: 844.246.3364



INFUSION ORDERS-TEPEZZA (TEPROTUMUMAB)

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

REFERRAL STATUS		
<input type="checkbox"/> New Referral	<input type="checkbox"/> Dose or Frequency Change	<input type="checkbox"/> Order Renewal

DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Thyroid Eye Disease	ICD 10 Code: E05.00
<input type="checkbox"/> Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis
<input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Labs and Tests supporting primary diagnosis

MEDICATION ORDERS
Initial IV dose: <input type="checkbox"/> Tepezza 10mg/kg IV once, initial dose
Maintenance Dosing (will start 3 weeks after initial dose, when applicable): <input type="checkbox"/> Tepezza 20mg/kg IV every 3 weeks x 7 doses
Other (please include dose, route, frequency, and number of refills): <input type="checkbox"/> 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:

Contact us with questions at: info@rosenursing.net
or call **954.432.8290**

Fax completed form and all documentation to **844.246.3364**

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