January 2026

Please fax completed form, insurance card, and clinical documentation to:
FAX: (843) 793-6181

TEPEZZA ORDER

☐ **New Start** ☐ **Maintenance: Last Dose Given_____________**

#doses already given__________

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	

Allergies ☐ NKDA ☐ Allergies: ____

Height: _________________________ Weight: _________________

Indication (ICD-10-CM):
☐ TED E05.00
☐ Other

DOSAGE ORDERS:
☐ Loading dose: 10mg/kg IV x 1 dose
☐ Maintenance: 20mg/kg IV every 3 weeks for 7 additional infusions
☐ Other

PREMEDICATION ORDERS:
☐ Acetaminophen: ☐ 1000mg PO ☐500mg PO 30 min prior to infusion.
☐ Diphenhydramine: ☐ 25mg PO ☐ 50mg PO ☐ 25mg IVP 30 min prior to infusion.
☐ Methylprednisolone: ☐ 62.5mg IVP ☐ 125mg IVP ☐ Other______ 30 min prior to infusion.
☐ Other ____

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive ALL the following:
☐ Face Sheet / Patient Demographics
☐ Insurance card(s) – copy of front & back
☐ Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes) Most Recent Labs (within last 4-8 weeks) – Required:
☐ CBC ☐ CMP ☐ TB ☐ Hep B
☐ Thyroid panel
☐ Hearing test: before, during, and after treatment
☐ Other: ____

DISCLAIMER: Referring provider attests to assess patients for elevated BGL and symptoms of hyperglycemia prior to infusion and will continue to monitor while on treatment. Referring provider will ensure patients with hyperglycemia or preexisting diabetes are under appropriate glycemic control before and while receiving Tepezza.