



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)	
Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION
<input type="checkbox"/> E05.00 Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm (hyperthyroidism) <input type="checkbox"/> Other ICD-10: _____
Does the patient have documented Thyroid Eye Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, date of diagnosis:</i> _____
Does the patient have a history of IBD? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No Clinical Activity Score (CAS): _____

DRUG ORDERS
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose/Frequency	Refills	
<input type="checkbox"/> Tepezza® (teprotumumab-trbw)	<input type="checkbox"/> Initial dose: 10 mg/kg (_____ mg) IV x 1 dose <input type="checkbox"/> Maintenance: 20 mg/kg (_____ mg) IV every 3 weeks x 7 doses, beginning 3 weeks after initial dose <input type="checkbox"/> Other: _____	_____	
Anaphylaxis	Dose/Strength	Directions	Refills
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 50mg IV <input type="checkbox"/> Other: _____	<input type="checkbox"/> Administer over at least 2 minutes as needed for mild to moderate infusion reaction <input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> Solu-Medrol	<input type="checkbox"/> 125 mg IV <input type="checkbox"/> Other: _____	<input type="checkbox"/> Administer over 3-5 minutes as needed for moderate to severe infusion reaction <input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> 0.3mg (0.3ml) <input type="checkbox"/> Other: _____	<input type="checkbox"/> Administer 0.3 mg by intramuscular injection as needed for signs/symptoms of anaphylaxis. May repeat dose after 5-10 minutes if necessary <input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> Other: _____	_____	_____	_____

SIGNATURE
We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.
X _____ Date: _____
Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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