TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

TEPEZZA®

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____
NPI #: _____ Tax ID: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Office Contact: _____ Phone: _____

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____
Plan #: _____
Group #: _____
RX Card (PBM): _____
BIN: _____ PCN: _____

Secondary Insurance (If Applicable): _____
Plan #: _____
Group #: _____
RX Card (PBM): _____
BIN: _____ PCN: _____

CLINICAL INFORMATION

☐ E05.00 Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm (hyperthyroidism) ☐ Other ICD-10: _____

Does the patient have documented Thyroid Eye Disease? ☐ Yes ☐ No *If yes*, date of diagnosis: _____

Does the patient have a history of IBD? ☐ Yes ☐ No Does the patient have diabetes? ☐ Yes ☐ No Clinical Activity Score (CAS): _____

DRUG ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

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