PARAGON HEALTHCARE

A Carelon Company

TEPEZZA (TEPROTUMUMAB) INFUSION ORDERS

P: 877-365-5566 | **F:** 855-889-2946

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:		Gender: ☐ Female ☐ Male	
Address:		City:	State:		ZIP:
Phone:	Email:	Height:	☐ inches ☐ cm	Weight:	☐ lbs. ☐ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: ☐ New to Therapy ☐ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:		Fax:	
Office Contact:				Email:	
Address:		City:	State:		ZIP:
NPI #:	DEA#:			Tax ID:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

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

Other orders: _____

Lab Orders: _____ Frequency: _____

☐ Serum glucose with each dose, Hgb A1C every 3 months (resulted after infusion)

☐ Serum glucose prior to each dose, Hgb A1C every 3 months (resulted prior to infusion)

Required labs to be drawn by: ☐ Paragon ☐ Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution.	☐ Dispense as written

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* 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.

Prescriber Signature: X	**Date:**

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COMPREHENSIVE SUPPORT FOR TEPEZZA (TEPROTUMUMAB) THERAPY

PATIENT INFORMATION

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
  - ☐ Indicate any symptoms the patient has:
    - ☐ Lid retraction ≥ 2 mm ☐ Moderate or severe soft tissue involvement
    - ☐ Exophthalmos ≥ 3 mm 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: _____
- ☐ Prescriber - please enroll patient in manufacturer HUB program