

**PATIENT INFORMATION:**

Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

**Patient Status:**  New to Therapy  Continuing Therapy **Next Treatment Date:** \_\_\_\_\_

**MEDICAL INFORMATION**
**Diagnosis:**  Thyrotoxicosis w diffuse goiter w/o thyrotoxic crisis or storm **ICD-10 Code:** E05.00

 Other: \_\_\_\_\_ **ICD-10 Code:** \_\_\_\_\_

Patient Weight: \_\_\_\_\_ lbs. (required) Allergies: \_\_\_\_\_

**THERAPY ORDER**
**Tepezza:**
 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)

**Lab Orders:**
 \_\_\_\_\_ **Frequency:**  Every infusion  Other: \_\_\_\_\_

 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

Other orders: \_\_\_\_\_

## Home IV Biologic Ana-kit Orders (adult):

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50mg orally OR IV
- 0.9% NS 1000mL bolus per protocol PRN

Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

**PROVIDER INFORMATION**

 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.

Provider Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider NPI: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_

 Opt out of Paragon selecting site of care (if checked, please list site of care): \_\_\_\_\_

**PREFERRED LOCATION**

City: \_\_\_\_\_ State: \_\_\_\_\_

View our locations here:



**PATIENT INFORMATION:**

Patient 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
  - CAS score: \_\_\_\_\_ 0-10 scale **(required)**
  - Indicate any symptoms the patient has:
    - Lid retraction  $\geq 2$  mm  Moderate or severe soft tissue involvement
    - Exophthalmos  $\geq 3$  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: \_\_\_\_\_

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

**Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance**