TEPEZZA (teprotumumab-trbw) Referral Order Form FAX (877) 637-6691

WWW.VASCOINFUSION.COM
PH: 602-346-0204 FAX: 877-637-6691

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions **indicate name of drug(s)* ____________

Vasco Infusion can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: ______________________________

DOB: ______________ SS# ______________

Phone # ______________

Email: ______________________________

PHYSICIAN INFORMATION

Referring Physician: ______________________________

Practice Address: ______________________________

____

Office Contact: ______________________________

Contact Phone # __________ Contact Fax # __________

NPI / TIN: ______________ ______________

TEPEZZA MEDICATION ORDERS

Patient Weight: ______kg

☐ Initial/Reload Dosing: 10mg/kg IV on day 1

☐ Maintenance Dosing: 20mg/kg IV every 3 weeks x 7 doses.

Premeds: __________

INDICATION/DIAGNOSIS

☐ E05.00
☐ E06.3
☐ Secondary diagnosis __________
☐ Other *(please specify in notes)*

***ICD-10** ______________________ **required**

______________________________ ____________
Referring Physician's Signature Date

NOTES (ADDITIONAL INFO)

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

APPOINTMENT DATE & TIME: ______________________________

FOR OFFICE USE ONLY