

**Patient's Information**

Date of Referral

First Name

Last Name

M.I.

Date of Birth

Address

City

State

ZIP Code

Phone

WT (kg)

HT (in)

Diagnosis

Allergies

**Please fax most recent glucose levels**

\*ICD 10 CODE

**\* Please include supporting clinical documentation for the specified ICD 10 Code as well as demographic and insurance information. This is necessary to ensure payment by the insurance carrier. Please fax with this order form. Initial appointment date and time will be verified after insurance approval.**

**TEPEZZA DOSING**

10mg/kg IV

Maintenance dose 20mg/kg IV every 3 weeks, remaining 7 infusions (8 total)

Refills:

Prescribing Provider

Address

City

State

ZIP Code

Provider  
Signature

Date/Time

Provider Phone

Provider Fax