HealthQuest
Infusion & Specialty

1311 W Sam Houston Pkwy N Ste 100, Houston, TX 77043
T (832) 612-3500 **F** (832) 500-8629 **E** specialty@hqrx.com

TEPEZZA REFERRAL FORM

DATE:______________ NEXT TREATMENT DATE:_____________

Please fax completed form along with copy of patient's insurance cards and any labs to **(832) 500-8629**

Patient Name ______________________________
Patient Address ______________________________
City ______________ State ________ Zip ________
Day Phone ______________ Work Phone # ______________
Cell Phone ______________________________
Date of Birth ______________ ☐ Male ☐ Female
E-mail ______________________________

Prescriber's Name ______________________________
DEA # ______________ NPI # ______________
Practice Name ______________________________
Office Contact ______________________________
Address ______________________ Suite # ________
City ______________ State ________ Zip ________
Phone ______________ Fax ______________

DIAGNOSIS

Patient: Wt.________ Ht.________ Allergies: ☐ Latex ☐ Other, specify ______________________

DIAGNOSIS

☐ Thyrotoxicosis w diffuse goiter w/o thyrotoxic crisis or storm **ICD-10 Code:** E05.00
☐ Other: ______________________ **ICD-10 Code:** ______________________

PRESCRIPTION

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)

Premedication orders: Tylenol ☐ 1000mg ☐ 500mg PO, please choose one antihistamine:
☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO ☐ Quzyttir 10mg IVP

Additional premedications: ☐ Solu-Medrol ______________ mg IVP ☐ Solu-Cortef ______________ mg IVP
☐ Other: ______________________________

Lab orders: ______________________ **Frequency:** ☐ Every infusion ☐ Other: ______________
☐ Yearly TB testing QFT (optional) Required labs to be drawn by: ☐ HealthQuest ☐ Referring physician

I authorize HealthQuest Infusion & Specialty and its representatives to initiate and execute any insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above as well as selecting the preferred site of care for the patient. I understand that I can revoke this designation at any time by providing written notice to HealthQuest Infusion & Specialty.

PRESCRIBER'S SIGNATURE (Signature required. No stamps.) ______________________ **DATE** ____________

IMPORTANT NOTICE: This facsimile is intended to be delivered to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee.

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COMPREHENSIVE SUPPORT FOR TEPEZZA THERAPIES

PATIENT INFORMATION

Patient Name ______________________________ Date of Birth ______________

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 contraindication 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 ≥ 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: ______________________________

HealthQuest Infusion & Specialty 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.

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