Please fax all pages of completed form to your team at 888.302.1028.
To reach your team, call toll-free 844.516.3319.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form
Tepezza®

accredo®

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient
Patient's first name _____ Last name _____ Middle initial _____
Preferred patient first name _____ Preferred patient last name _____
Sex at birth: ☐ Male ☐ Female Gender identity _____ Pronouns _____ Last 4 digits of SSN _____
Date of birth _____ Street address _____ Apt # _____
City _____ State _____ Zip _____
Home phone _____ Cell phone _____ Email address _____
Parent/guardian (if applicable) _____
Home phone _____ Cell phone _____ Email address _____
Alternate caregiver/contact _____
Home phone _____ Cell phone _____ Email address _____
☐ OK to leave message with alternate caregiver/contact
Patient's primary language: ☐ English ☐ Other If other, please specify _____

Provider will read the following statement: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____
Office/clinic/institution name _____
Prescriber info: Prescriber's first name _____ Last name _____
Prescriber's title _____ If NP or PA, under direction of Dr. _____
Office phone _____ Fax _____ NPI # _____ License # _____
Office contact and title _____ Office contact email _____
Office street address _____ Suite # _____
City _____ State _____ Zip _____
Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site If infusion site, complete information below dotted line:

Infusion info: Infusion site name _____ Clinic/hospital affiliation _____
Site street address _____ Suite # _____
City _____ State _____ Zip _____
Infusion site contact _____ Phone _____ Fax _____ Email _____

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____ Has the patient been treated previously for this condition? ☐ Yes ☐ No
Is patient currently on therapy? ☐ Yes ☐ No Please list all therapies tried/failed: _____
Patient wt _____ Date wt obtained _____
☐ NKDA ☐ Known drug allergies _____
Concurrent meds _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

INFUSION LOCATION: ☐ Patient's home ☐ Healthcare facility

Medication	Strength/Formulation	Directions	Quantity/Refills
Tepezza®	500mg vial	Infuse 10mg/kg intravenously for the initial infusion followed by 20mg/kg intravenously every 3 weeks thereafter for a total of 8 infusions. Administer the first 2 infusions over 90 minutes. Subsequent infusions may be reduced to 60 minutes, if tolerated. **Please see Dosing and Administration section of Prescribing Information for additional instruction.** Infusion 1: _____ mg (10mg/kg) for initial dose Infusions 2 through 8: _____ mg (20mg/kg) infused every 21 days ☐ Patient is Medically Urgent. I attest the patient is both (1) experiencing compressive optic neuropathy secondary to Thyroid Eye Disease and (2) requires accelerated treatment with TEPEZZA	Dispense: **Infusion 1:** 21-day supply No refills **Infusions 2 through 8:** 21-day supply Refills: 6 ☐ **Other:** Infusions _____ through _____ 21-day supply Refills: _____ If patient is established on therapy, please advise which infusions are needed above.

Required medication and supplies for home infusion (please complete this section for home infusions only)

Premedication orders:

☐ _____

Send quantity and refills sufficient for days supply for medication infusion.

Infusion method: Gravity unless otherwise instructed

Fluids for administration and reconstitution (please strike through if not required)

Sterile Water for reconstitution (10mL per vial of Tepezza)

NS 0.9% for dilution (100mL for doses < 1800mg)

NS 0.9% for dilution (250mL for doses ≥ 1800mg)

NS 0.9% Flush (if central venous access, sterile flush will be provided)

All Tepezza orders to be administered via peripheral line unless otherwise instructed.

Choose administration access: ☐ Peripheral access ☐ Central venous access

If central venous access: Flush with 10mL Sterile NS 0.9% before and after infusion.

☐ Follow with heparin 100units/mL 5mL final flush

If peripheral access: Flush with 3mL NS 0.9% before and after infusion and as needed

Hypersensitivity/Anaphylaxis: Stop infusion

Medicate with:

Epinephrine/EpiPen 0.3mg IM as needed for anaphylaxis for patients weighing ≥30kg (or 0.15mg for patients weighing <30kg)

☐ Other _____

☐ Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy. *If nursing services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.
If shipped to physician's office, physician accepts on behalf of patient for administration in office.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

_____ **Date** _____ **Dispense as written** _____ **Date** _____ **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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