Care Fusion INFUSION CENTERS

AIC Ophthalmology **Fax: 855-733-9898**
Phone: 877-460-3905

Patient Information

Patient Name: _____ DOB: _____ Height: _____ Patient Contact #: _____

Medical Assessment

Diagnosis (ICD-10):

- ❑ E05.00 – Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm (hyperthyroidism)
- ❑ Other: _____

Clinical Activity Score (CAS): _____ Date of Thyroid Eye Disease Diagnosis: _____

Failed Medications: _____

****Please include a demographics page, front and back of an insurance card, any clinical notes with supporting diagnosis, lab-work, tests, and any other supporting documentation including past tried and / or failed therapies associated with diagnosis****

Allergies: _____

Pre-Medication Orders:

- ❑ APAP □ 325mg □ 500mg □ 650mg - PO 30 minutes before infusion.
- ❑ Diphenhydramine □ 25mg □ 50mg – PO 30 minutes before infusion OR □ 25mg IVP □ 50mg IVP
- ❑ Alternate Oral Antihistamines: □ Cetirizine 10mg □ Loratadine 10mg □ Fexofenadine 60mg or □180mg
- ❑ Methylprednisolone □ 40mg IVP □ 125mg IVP or other ____ mg IVP
- ❑ Famotidine □ 20mg PO □ 40mg PO □ 20mg IVP □ 40mg IVP
- ❑ Ondansetron □ 4 mg IVP □ 4 mg PO

Labwork: Blood glucose test every _____ infusion(s). Other labs (e.g., thyroid, pregnancy): _____

To be Drawn by: □ Infusion Clinic □ Referring Provider

Medication

Patient's Current Weight: _____ lbs / kg (circle one)

Tepezza *(teprotumumab-trbw)*

- ❑ **Induction**: _____ mg (10mg / kg) at week 0
- ❑ **Subsequent**: _____ mg (20mg / kg) at week 3 and every 3 weeks x 7 additional doses
- ❑ **Refills: ____**

Lumvoa *(veligrotug-vvze)*

- ❑ **Dose**: _____ mg (10mg / kg) every 3 weeks x 5 infusions
- ❑ **Refills: ____**

Physician Prescription Orders

Address: _____ Phone: _____ Fax: _____

Physician Name: _____ Clinic Contact: _____

NPI #_____Physician Signature: _____***Date:*** _____