

Tepezza ® | (teprotumumab-trbw)

Please fax a copy of the following patient information:



Demographics Insurance information Current Lab Results H&P Current Medication

Patient Information



Patient Name: _____ DOB: _____

Allergies: _____ Weight: _____ lbs/kg Height: _____

Diagnosis/ ICD-10:

Thyroid Eye Disease (Graves' Disease) / E05.00

Other (please specify) _____

Additional information:

Provider Information



Printed Provider's Name:

Phone: _____ Fax: _____

Office Address:

Contact Person: _____

Medication Information



Dose: _____ Frequency and Duration: _____

Start Date of Infusion: _____ End Date of Infusion: _____

Other Orders or Special Instructions:

