

REFERRAL STATUS

- NEW REFERRAL
 DOSE/FREQUENCY CHANGE
 ORDER RENEWAL

PATIENT INFORMATION

NAME: _____

DATE OF BIRTH: ____/____/____

PHONE: (____) _____-_____

ALLERGIES: _____

WEIGHT: _____LBS HEIGHT: _____IN

PLEASE ATTACH DEMOGRAPHICS, CLINICALS, AND LABS

PROVIDER INFORMATION

NAME: _____

NPI: _____

SIGNATURE: _____

PHONE: (____) _____-_____

FAX: (____) _____-_____

CONTACT PERSON: _____

DATE: ____/____/____ REFILLS: _____

ALL ORDERS ARE VALID FOR ONE YEAR, UNLESS SPECIFIED

MEDICAL INFORMATION (REQUIRED)

- TEPEZZA: CAS SCORE, PATIENT ENROLLMENT SUBMITTED TO TEPEZZA, GLUCOSE TEST IF PATIENT IS DIABETIC
 PROLIA/EVENITY/BONIVA/RECLAST: CALCIUM LEVELS, BONE DENSITY (<-2.5, OR DOCUMENTED FRACTURES)
 APRETUDE: HIV-1RNA AND ANTIBODY, LFTS IF AVAILABLE
 EVKEEZA/LEQVIO: LDL-C LAB

MEDICATION ORDERS

- TEPEZZA 10MG/KG IV ON WEEK 0 FOR ONE INFUSION
 TEPEZZA 20MG/KG IV ON WEEK 3, AND EVERY 3 WEEKS THEREAFTER X 7 INFUSIONS

 FABRAZYME 1MG/KG IV EVERY 2 WEEKS
 *PREMEDICATE: TYLENOL 1000MG PO, BENADRYL 25MG PO
 SOLUMEDROL 100MG IV (30 MIN PRIOR)

 SALINE SUPPRESSION TEST
 NORMAL SALINE 500ML/HR IV OVER 4 HOURS
 RENIN AND ALDOSTERONE SERUM TO BE DRAWN BEFORE/AFTER INFUSION

 EVKEEZA 15MG/KG IV EVERY 4 WEEKS

 LEQVIO 284MG SQ DAY 1, THEN 3 MONTHS LATER, AND EVERY 6 MONTHS THEREAFTER
 LEQVIO 284MG SQ EVERY 6 MONTHS

 ZOLEDRONIC ACID/RECLAST 5MG/100ML IV SINGLE DOSE

 EVENITY 210MG SQ MONTHLY FOR ONE YEAR

 PROLIA 60MG SQ ONCE EVERY 6 MONTHS

 BONIVA 3MG IV EVERY 3 MONTHS

 APRETUDE 600MG IM MONTHLY X 2 DOSES, THEN EVERY 2 MONTHS THEREAFTER
 APRETUDE 600MG IM EVERY 2 MONTHS

DIAGNOSIS

- E05.00 THYRO W/ DIFFUSE GOITER W/O GOUT THYRO CRISIS OR STORM (HYPERTHY)
 I15.2 HYPERTENSION SECONDARY TO ENDOCRINE DISORDERS
 E78.01 FAMILIAL HYPERCHOLESTEROLEMIA
 M80.0 ____ AGE-RELATED OSTEOPOROSIS WITH CURRENT PATHOLOGICAL FRACTURE
 M81.0 AGE-RELATED OSTEOPOROSIS W/O CURRENT PATHOLOGICAL FRACTURE
 M81.8 OTHER OSTEOPOROSIS W/O CURRENT PATHOLOGICAL FRACTURE

 OTHER: _____
 ICD-10: _____

PRE-MEDICATIONS

BENADRYL IV _____ MG
 REGLAN IV _____ MG
 SOLUMEDROL IV _____ MG
 ZOFRAN IV _____ MG
 OTHER IV _____ MG

 BENADRYL PO _____ MG
 TYLENOL PO _____ MG
 ZYRTEC PO _____ MG
 ZOFRAN PO _____ MG
 ZANTAC PO _____ MG
 OTHER PO _____ MG

BY SIGNING THIS FORM AND UTILIZING OUR SERVICES, YOU ARE AUTHORIZING OUR COMPANY (BASED ON PREFERRED LOCATION) AND ITS EMPLOYEES TO SERVE AS YOUR PRIOR AUTHORIZATION AND SPECIALTY PHARMACY DESIGNATED AGENT IN DEALING WITH MEDICAL AND PRESCRIPTION INSURANCE COMPANIES. THE INFORMATION IN THIS TRANSMISSION MAY CONTAIN PRIVILEGED AND CONFIDENTIAL INFORMATION, INCLUDING PATIENT INFORMATION PROTECTED BY FEDERAL AND STATE PRIVACY LAWS. IT IS INTENDED ONLY FOR THE USE OF THE PERSON(S) NAMED ABOVE. IF YOU ARE NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY REVIEW, DISSEMINATION, DISTRIBUTION, OR DUPLICATION OF THIS COMMUNICATION IS STRICTLY PROHIBITED. IF YOU ARE NOT THE INTENDED RECIPIENT, PLEASE CONTACT THE SENDER BY REPLY EMAIL AND DESTROY ALL COPIES OF THE ORIGINAL.