PARAGON
INFUSION CENTERS

TEPEZZA
INFUSION ORDERS

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION /MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

Diagnosis: ☐ Thyroid Eye Disease ICD-10 Code: _____

Patient Weight: _____ lbs.

Allergies: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

☐ If diabetes history, glucose is under control

Lab Orders: _____

TEPEZZA INFUSION ORDERS

☐ 10mg/kg IV for the first infusion, followed by 20mg/kg IV every 3 weeks for 7 additional infusions.

* Patients with pre-existing diabetes should be under appropriate glycemic control before receiving Tepezza*

**** Once we receive the necessary documentation, we will schedule the patient's treatment**

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc.and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Date: _____

Physician Name: _____

Phone: _____ Fax: _____ Contact Person: _____

INFUSION CENTER LOCATIONS

Phone: 877-365-5566 **Fax: 855-889-2946**	**Texas** ☐ Arlington ☐ Austin ☐ Dallas ☐ Houston ☐ North Hills ☐ Plano ☐ Round Rock ☐ San Antonio ☐ Stone Oak	**Tennessee** ☐ Knoxville	**Georgia** ☐ Atlanta

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