

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

PARAGONHEALTHCARE.COM

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