Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

Tepezza Request

2301 Evesham Road, Building 800, Suite 115
Voorhees, New Jersey 08043
T. (866)497-0905
F.(609)228-9798 Attn: Idyllic Infusion Coordinator

DATE:	
REFERRING PROVIDER INFORMATION	
Requesting Provider Name and NPI **Tax ID#**	**Name:** **NPI:** **Tax ID#**
Fax Number	
Practice Contact (Name/Phone number)	
Email of Contact	
We will gladly remind your patient to schedule routine follow-up visits with your office. **Return to Referring Provider (frequency): EVERY _____ WKS / MOS**	
PATIENT INFORMATION	
Patient Name	
Date of Birth	/ /
Height in ft/in: **Weight in lbs:**	
Insurance(s): include copies of front and back	
Preferred Treatment Location	☐ Voorhees ☐ Moorestown ☐ Wall/Manasquan ☐ Sewell ☐ Hamilton ☐ Galloway
Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:

Diagnosis:
▫ E05.00 – Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm (hyperthyroidism)

▫ Other: _____

The following information is required for authorization for Tepezza:

- Most recent Clinical Activity Score (CAS): _____ Date _____
- Patient's Thyroid Eye Disease (TED) is: ▫ active ▫ inactive
- Patient's (TED) is: ▫ mild ▫ moderate ▫ mod/severe ▫severe
- Please provide information on the patient's TED symptoms:
  - Moderate or severe soft-tissue involvement: ▫ Yes ▫ No
  - Diplopia: ▫ Yes ▫ No
  - Lid Retraction: ▫ Yes (If yes, how many mm? _____) ▫ No
  - Exophthalmos / Proptosis? ▫ Yes (# mm above normal? ____) ▫ No
- Has the patient previously been treated with Tepezza? ▫ Yes ▫ No
  - (If yes, how many treatments? _____)
- Has the patient previously had orbital decompression surgery for their TED? ▫ Yes ▫ No (If yes, when? _____)
- Is the patient's TED condition sight threatening if surgery is not immediately obtained? ▫ Yes ▫ No
- Has the patient previously had orbital radiation for their TED? ▫ Yes (when? _____) ▫ No
- Does the patient have corneal decompensation that is unresponsive to medical management? ▫ Yes ▫ No
- Please provide information on steroid use for the patient's TED symptoms:
  - Has the patient tried steroids but had unsatisfactory results: ▫ Yes ▫ No
  - Are steroids contraindicated in this patient? ▫ Yes ▫ No
    - (If yes, why? _____)
  - Is the patient diabetic? ▫ Yes ▫ No
    - (If yes, is it under control? Yes No)
  - Does the patient have any reduction in visual acuity due to optic neuropathy in the past 6 months? ▫ Yes ▫ No

- Is the patient planning to concurrently use any other biological immunomodulator? ☐ Yes ☐ No
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- Please attach the following results (from within last 90 days):
  - T3 (free)
  - T4 (free)

PLEASE NOTE:

- Please attach a copy of medication order to this document when transmitting to ARBDA/IDYLLIC. Prescription should include standard information as well as specific instructions if loading doses of desired RX is required.
  - ** NOTE ** Please do NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
  - OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS
  - Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.

- Please include any information to support the clinical rationale for starting TEPEZZA treatment.
- Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- **!! IMPORTANT !!** Please notify our office if/when the medication is discontinued

Ordering Provider Signature: _____