InfuseCare

TEPEZZA INFUSION order

Patient Name DOB

Phone M F

DIAGNOSIS *Please provide ICD-10 code*

PRE-MEDICATION

(other)

ORDERS

DOSAGE

PATIENT WEIGHT

lbs.

kg

NOTES

ORDERING PROVIDER

Signature **X** ______________________________ Date

Provider Phone Fax

Please return by fax to: (806) 503-2200 or email to: referrals@icareama.com.