ThrIVewell
INFUSION

Infusion Order

Note: This form is being provided as a guide. Prescribers should use their clinical judgment when completing. Some facilities prefer to use their own infusion order form. Check with your patient's facility before writing your infusion order.

Patient Information

Patient name:	**DOB:**	**Sex:** ☐ **M** ☐ **F**	**Weight:** ☐ kilo ☐ lb
Phone number:	**Email:**		
Allergies:	**ICD-10 code:**		
Is the patient diabetic? ☐ **Yes** ☐ **No**	**Does the patient have a history of IBD?** ☐ **Yes** ☐ **No**		
Emergency contact name:	**Phone number:**		

Please attach: 1. List of current medications, 2. Copy of the patient's insurance card, 3. Clinical progress notes and history and physical (H&P) to support diagnosis, and 4. Relevant labs.

Physician Information

Prescribing physician's name:	**Practice name:**
Phone number:	**Fax number:**
Email:	**Office contact:**
Co-managing physician name:	**Phone number/email:**

Medication Order

Medication: TEPEZZA (teprotumumab-trbw)

Dose: Infusion 1:_____mg (10 mg/kg) Infusions 2 to 8:_____(20 mg/kg)

Duration: Administer the first 2 infusions over 90 minutes. Subsequent infusions may be reduced to 60 minutes if well tolerated (see note below for additional information).

Saline bag: Administer via an infusion bag containing 0.9% Sodium Chloride Solution, USP. For doses <1800 mg, use a 100-mL bag. For doses ≥1800 mg, use a 250-mL bag.

Schedule: Q3 weeks, 8 infusions total

Preferred start date:_____

Pretreatment medications:_____

Note: TEPEZZA does not require a specific protocol for premedications; follow your facility protocol. If the patient experiences an infusion reaction, consider premedication for subsequent doses (see note below for additional information).

Notes:

- ☐ If an infusion reaction occurs, interrupt or slow the rate of infusion and use appropriate medical management. For subsequent infusions, slow infusion to 90 minutes and consider premedicating with an antihistamine, antipyretic, and/or corticosteroid. Follow your facility protocol and notify the prescriber.
- ☐ Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting, and/or dressing changes.
- ☐ Share post-infusion chart notes with the prescriber.
- ☐ Other notes:

Lab Orders

Standing labs:

- Blood glucose test every_____infusion(s)
- Other labs (e.g. thyroid, pregnancy):_____

☐ Share lab results with co-managing physician.

Physician signature:_____

If using this as an order form, must fill out with signature.

Please see Important Safety Information on next page and accompanying Full Prescribing Information.

Insurance Information

☐ Request priror authorization support (please sned digital documentation)

Primary Insurance _____ Insurance company _____

Policy # _____

Policyholder's first and last name _____ Policyholder's DOB: _____ (MM/DD/YYYY)

Second Insurance _____ Policy #/ Group # _____

Patient Enrollment Form

Once complete, submit by Fax 1-833-469-8333 or email **TEPEZZAHBYS@horizontherapeutics.com**

HORIZON BY your side | TEPEZZA® teprotumumab-trbw

Complete all required fields, including prescriber's signature and date, to initiate patient enrollment process.

For patient support and/or assistance obtaining patient signature, call Horizon By Your Side at 1-833-5-TEPEZZA (1-833-583-7399).

PATIENT INFORMATION (* indicates a required field)

First name* _____ **Last name*** _____

Sex: ◯ Male ◯ Female

Date of birth*: ____/____/____ (MM/DD/YYYY)

Primary language _____ Email address _____

Primary telephone* _____

Consent to leave voice message at patient and/or alternate contact telephone? ◯ Yes ◯ No

◯ Home ◯ Cell

Consent to send text message? ◯ Yes ◯ No

Address* _____

City* _____ **State*** _____ **ZIP code*** _____

Alternate contact name _____ Alternate contact telephone _____

DIAGNOSIS (* indicates a required field) (Required for benefits investigation)

PRIMARY DIAGNOSIS CODE*: Please select one.

◯ E05.00 — Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm (hyperthyroidism)

◯ Other ICD-10 code: _____

Clinical Activity Score (CAS): _____

Date of Thyroid Eye Disease (TED) Diagnosis: ____/____/____

Additional disease manifestation codes: _____

INSURANCE INFORMATION (* indicates a required field) (Please include front and back copies of insurance card[s] with this form)

Primary insurance* _____ Secondary insurance _____

Policy #* _____ Policy # _____

Policyholder's first and last name* _____ Policyholder's first and last name _____

Insurance company telephone* _____ Insurance company telephone _____

Group #* _____ Group # _____

Policyholder's Date of birth*: ____/____/____ (MM/DD/YYYY)

Policyholder's Date of birth*: ____/____/____ (MM/DD/YYYY)

◯ Patient is uninsured to my knowledge.

State requirements: The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

PATIENT AUTHORIZATION (Required—please see authorization language on the next page)

> _____ **Patient signature** *Please read page 2*

Date: ____/____/____ (MM/DD/YYYY)

Printed full name _____

PRESCRIBER INFORMATION (* indicates a required field)

First name* _____ **Last name*** _____

Address* _____

City* _____ **State*** _____ **ZIP code*** _____

NPI #* _____ **Tax ID #*** _____ **State license #*** _____

Clinic/hospital affiliation _____

Office contact name* _____

Office contact telephone* _____ **Fax*** _____

Email address* _____

Preferred communication: ◯ Telephone ◯ Email

Prescriber's specialty: _____

Referring physician: Was this patient referred to you by another physician? ◯ Yes ◯ No

Name: _____ Specialty: _____

City _____ State _____

ZIP code _____ Telephone _____

INFUSION FACILITY

Do you have a preferred infusion facility? ◉ Yes ◯ No If yes, please fill out the preferred infusion facility information below. If no, Horizon By Your Side can provide options for your patient.

THRIVEWELL INFUSION
Facility name

Facility address _____

City _____ State _____ ZIP code _____

212-803-3339
Telephone

646-768-8600
Fax

1750898565
Facility NPI #

Facility tax ID # _____

PRESCRIPTION INFORMATION (Required for specialty pharmacy benefit or home infusion)

Medication: TEPEZZA® (teprotumumab-trbw) for injection, for intravenous use // 500-mg vial

Duration: 1 infusion every 3 weeks for a total of 8 infusions. Administer the first 2 infusions over 90 minutes. Subsequent infusions may be reduced to 60 minutes, if tolerated. Please see Dosing and Administration section of Prescribing Information for additional instruction.

Dose*: Week 0: _____ mg (10 mg/kg) 21-day supply; 1 prescription; no refill

Week 3: _____ mg (20 mg/kg) 21-day supply; 1 prescription; 6 refills; q3wk

Weight*: _____ ◯ kg ◯ lbs

◯ **Patient is Medically Urgent**. Medically Urgent means the patient both (1) is experiencing compressive optic neuropathy secondary to Thyroid Eye Disease and (2) requires accelerated treatment with TEPEZZA.

Allergies*: _____ or ◯ No known drug allergies (NKDA)

Route of administration: Peripheral IV

◯ Authorize administration supplies as needed

Fluids for reconstitution/administration: Reconstitute each vial with 10 mL of sterile water for injection, USP. Administer via an infusion bag containing 0.9% sodium chloride solution, USP. For doses <1800 mg, use a 100 mL bag. For doses ≥1800 mg, use a 250 mL bag.

◯ **Nursing orders:** Provide skilled nursing visit to administer medication, provide education, and assess patient (required for home infusion).

PRESCRIBER CERTIFICATION (Required—please see certification language on the next page)

> _____ **Prescriber signature/Dispense as written*** Substitutions allowed

Date*: ____/____/____ (MM/DD/YYYY)

Written or e-signature only; stamps not acceptable.

◯ **I certify that the above therapy is medically necessary for the treatment of documented Thyroid Eye Disease (TED)***

The above signature grants permission to share records with the co-management team and infusion facility.

Please see Important Safety Information on next page and Full Prescribing Information at TEPEZZAhcp.com.

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Prescriber Certification

Please read and provide signature in Prescriber Certification section on page 1

I certify that the above therapy is medically necessary, that the information provided is accurate to the best of my knowledge and that my patient is being administered TEPEZZA (teprotumumab-trbw), for intravenous infusion in accordance with the labeled use of the product. I understand that Horizon Therapeutics USA, Inc. and its affiliates and their respective employees or agents (collectively, "Horizon") will use this information to administer the Horizon By Your Side program (the "Program"), which provides a wide array of patient-focused services, including providing logistical and non-medical treatment support for TEPEZZA, as prescribed, and educating about the insurance process. I authorize these parties to act on my behalf for the limited purposes of transmitting this prescription by facsimile to the appropriate pharmacy designated by the patient utilizing their benefit plan. By my signature, I also certify that (1) my patient or his/her personal representative has provided a signed HIPAA authorization that allows me to share protected health information with Horizon for purposes of the Program and (2) I have obtained the patient's authorization to release such information as may be required for AllCare Plus Pharmacy (or another party acting on behalf of Horizon) to assess insurance coverage for TEPEZZA and assistance in initiating or continuing TEPEZZA as prescribed. I further understand and agree that (a) any medication or service provided through the Program as a result of this form is for the named patient only and is not being made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use TEPEZZA or any other Horizon product or service, for any other person; (b) my decision to prescribe TEPEZZA was based solely on my professional determination of medical necessity; and (c) I will not seek reimbursement for any medication or service provided by or through the Program from any government program or third-party insurer. I understand that Horizon may modify or terminate the Program at any time without notice. The completion and submission of coverage- or reimbursement-related documentation are the responsibility of the patient and healthcare provider. Horizon makes no representation or guarantee concerning coverage or reimbursement for any item or service. On behalf of the patient, Horizon expects the prescriber to coordinate with Horizon By Your Side to provide, to the best of the prescriber's ability, in-network infusion services and work with Horizon By Your Side to effectively communicate both in-network and out-of-network choices and the corresponding financial obligations of the patient connected to each choice. Should the prescriber knowingly perform out-of-network services without the knowledge and consent of the patient, the prescriber cannot balance bill the patient for the out-of-network services.

State requirements: The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

By filling out and signing this form, the enrollment process in Horizon By Your Side has initiated; however, your patient must sign a Patient Authorization to complete enrollment in Horizon By Your Side. Please note that your patient will not benefit from the services and support offered by the Program unless your patient signs a Patient Authorization, consenting to receiving such services. If your patient does not sign the Patient Authorization contained within this form, Horizon will contact the patient to determine whether the patient is interested in signing a separate Patient Authorization.

Patient Consent for Patient Information, Enrolling in Services, and Accessing Financial Support (referred to as "Patient Authorization")

Please read and provide signature in Patient Authorization section on page 1

I hereby authorize my healthcare providers, my health insurance carriers, and my pharmacies to use and disclose my individually identifiable health information, including my medical records, insurance coverage information, and my name, address, and telephone number to Horizon Therapeutics USA, Inc. and its affiliates and their respective agents and representatives (collectively, "Horizon"), including third parties authorized by Horizon to administer drug support and to dispense drugs (collectively, "Horizon By Your Side") for the following purposes: (1) to establish eligibility for benefits; (2) to communicate with my healthcare providers and me about my treatment or condition and related products; (3) to facilitate the provision of products, supplies, or services by a third party including, but not limited to, specialty pharmacies; (4) to register me in any applicable product registration program required for my treatment; (5) to enroll me in eligible patient support programs offered by Horizon By Your Side and/or Horizon, including nursing or patient access support services (government-reimbursed programs may not be eligible for all support services offered; please contact Horizon By Your Side for determination); and (6) to send me marketing information or offer me products and services related to my treatment or condition (or other products or services in which I might be interested) and to contact me occasionally to obtain my feedback (for market research purposes only) about my treatment, my condition, or my experience with Horizon and/or Horizon By Your Side otherwise as required or permitted by law. Further, I appoint the Program, on my behalf, to proceed with Program services and to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. I understand the pharmacies may receive a fee from Horizon in exchange for (1) providing me with certain materials and information described above, and (2) using or disclosing certain health information pursuant to this Authorization.

I understand that Horizon, as well as my healthcare providers, cannot require me, as a condition of having access to medications, prescription drugs, treatment, or other care, to sign this Authorization. I understand that I am entitled to a copy of this Authorization.

I understand that information disclosed pursuant to this Authorization in some cases may be redisclosed by the recipient and no longer protected by HIPAA or other privacy laws. But Horizon has agreed to use and disclose my information only for purposes of operating the Program. I understand that I may cancel this Authorization at any time by mailing a signed letter requesting such cancellation to Horizon By Your Side, 1 Horizon Way, Deerfield, IL 60015, but that this cancellation will not apply to any information used or disclosed by my healthcare providers and/or health insurance carriers based on this Authorization before they are notified that I have cancelled it. Unless required by state law, this Authorization is valid for whichever is greater: (a) the duration remaining on this treatment or (b) 10 years from the date signed on page 1. A photocopy of this Authorization will be treated in the same manner as the original.

INDICATION

TEPEZZA is indicated for the treatment of Thyroid Eye Disease.

IMPORTANT SAFETY INFORMATION

Warnings and Precautions

Infusion Reactions: TEPEZZA may cause infusion reactions. Infusion reactions have been reported in approximately 4% of patients treated with TEPEZZA. Reported infusion reactions have usually been mild or moderate in severity. Signs and symptoms may include transient increases in blood pressure, feeling hot, tachycardia, dyspnea, headache, and muscular pain. Infusion reactions may occur during an infusion or within 1.5 hours after an infusion. In patients who experience an infusion reaction, consideration should be given to premedicating with an antihistamine, antipyretic, or corticosteroid and/or administering all subsequent infusions at a slower infusion rate.

Preexisting Inflammatory Bowel Disease: TEPEZZA may cause an exacerbation of preexisting inflammatory bowel disease (IBD). Monitor patients with IBD for flare of disease. If IBD exacerbation is suspected, consider discontinuation of TEPEZZA.

Hyperglycemia: Increased blood glucose or hyperglycemia may occur in patients treated with TEPEZZA. In clinical trials, 10% of patients (two-thirds of whom had preexisting diabetes or impaired glucose tolerance) experienced hyperglycemia. Hyperglycemic events should be managed with medications for glycemic control, if necessary. Monitor patients for elevated blood glucose and symptoms of hyperglycemia while on treatment with TEPEZZA. Patients with preexisting diabetes should be under appropriate glycemic control before receiving TEPEZZA.

Adverse Reactions

The most common adverse reactions (incidence ≥5% and greater than placebo) are muscle spasm, nausea, alopecia, diarrhea, fatigue, hyperglycemia, hearing impairment, dysgeusia, headache, dry skin, and menstrual disorders.

For additional information on TEPEZZA, please see Full Prescribing Information at TEPEZZAhcp.com.

HORIZON

TEPEZZA®
teprotumumab-trbw