

TN  
100 Covey Drive  
Suite 307  
Franklin, TN 37067



# Thyrotropin Alfa (Thyrogen) Provider Order Form

Date: \_\_\_\_\_

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order	

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

PRE-MEDICATION ORDERS
<input type="checkbox"/> acetaminophen (Tylenol) <input type="checkbox"/> 500mg / <input type="checkbox"/> 650mg / <input type="checkbox"/> 1000mg PO
<input type="checkbox"/> cetirizine (Zyrtec) 10mg PO
<input type="checkbox"/> loratadine (Claritin) 10mg PO
<input type="checkbox"/> diphenhydramine (Benadryl) <input type="checkbox"/> 25mg / <input type="checkbox"/> 50mg <input type="checkbox"/> PO / <input type="checkbox"/> IV
<input type="checkbox"/> methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg / <input type="checkbox"/> 125mg IV
<input type="checkbox"/> hydrocortisone (Solu-Cortef) <input type="checkbox"/> 100mg IV
<input type="checkbox"/> Other: _____
Dose: _____ Route: _____
Frequency: _____

  

SPECIAL INSTRUCTIONS
<div style="border: 1px solid black; height: 150px; width: 100%;"></div>

THERAPY ADMINISTRATION
<input type="checkbox"/> <b>Thyrotropin Alfa</b> (Thyrogen) intramuscular injection
▪ Dose: 0.9mg intramuscular injection
▪ Frequency: two injections separated by 24 hours
<input type="checkbox"/> Patient is required to stay for 30-minute observation period
Total dosages _____
Refills _____

NOTES/ADDITIONAL COMMENTS:
<div style="border: 1px solid black; height: 50px; width: 100%;"></div>

## ORDERING PROVIDER

Signature   X   \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_