

THYROGEN® (thyrotropin alfa) Referral Form



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PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

DOB: _____ Patient Name: _____ Patient Phone: _____

Patient Address: _____ Patient Email: _____

NKDA Allergies: _____ Weight (lbs/kg): _____ Height: _____

ICD-10 code (required): _____ ICD-10 description: _____ Last Treatment Date: _____ Last 4 SSN: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

NURSING

Infusion to be administered per BioHealth protocols.

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- CRP at each dose every _____
- OTHER _____

PREMEDICATIONS

- acetaminophen (Tylenol) 500mg 650mg / 1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl) 25mg 50mg PO IV
- methylprednisolone (Solu-Medrol) 40mg 125mg IV
- hydrocortisone (Solu-Cortef) 100mg IV
- Other: _____
- Dose: _____ Route: _____
- Frequency: _____

THYROGEN THERAPY ADMINISTRATION

0.9mg intramuscular injection followed by 0.9 mg intramuscular injection 24 hours later

REQUIRED DOCUMENTATION

- Patient Demographics**
- Insurance Card/Information**
- Progress Notes Supporting DX**
- Medication List and H&P**

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print) _____ Provider Signature _____ Date _____

Have a Question? (786)460-6044
 Fax Referral Form To: (786)219-3917
 8684 SUNSET DRIVE MIAMI FL 33143