

Tepezza (teprotumumab-trbw)

PATIENT INFORMATION

Referral Status (check one): New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____

NKDA Allergies: _____ Weight _____ Please specify: lbs kg Height: _____

Patient Status (check one): New to Therapy Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

PRE-MEDICATION ORDERS

- 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: _____

THERAPY ADMINISTRATION

- Teprotumumab-trbw** (Tepezza) in 0.9% sodium chloride, intravenous infusion
 - Dose: (Indicate if patient has received any previous doses.)
 - 10mg/kg for the first infusion
 - 20mg/kg for infusions 2-8
 - Frequency: Every 3 weeks, 8 total infusions.
 - Administer the first 2 infusions over 90min. Subsequent infusions may be reduced to 60min if well tolerated. If reaction occurs, interrupt or slow the rate of infusion.
 - Dilute with 0.9% Sodium Chloride. For doses <1800mg use a 100ml bag. For doses ≥1800mg use a 250ml bag. (Remove equal volume.)
- Flush with 0.9% sodium chloride at the completion of infusion
- Patient is required to stay for 30-minute observation period
- Order is valid for 8 total infusions unless otherwise indicated. (Order will expire one year from date signed)

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

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

 Provider Name (Print)

 Provider Signature

 Date