

# Tepezza (teprotumumab-trbw) | Order Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## 1. For new patients, please submit with form:

☒ Copy of insurance card ☒ Patient demographics ☒ History & physical ☒ Pertinent labs and test results

## 2. Patient Information

☐ Male ☐ Female Height: \_\_\_\_\_ in/cm Weight: \_\_\_\_\_ lbs/kg ☐ NKDA Allergies: \_\_\_\_\_  
Is this the first dose? ☐ Yes ☐ No, date of last infusion: \_\_\_\_\_ Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

## 3. Diagnosis and Clinical Information

Diagnosis: ☐ Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm (hyperthyroidism)  
☐ Other: \_\_\_\_\_ ICD-10: \_\_\_\_\_

## 4. Prescription Information

<b>Medication</b>	Tepezza 500mg vial
<b>Dosing / Frequency</b>	<input type="checkbox"/> Initial dose: 10 mg/kg ( _____ mg) IV x 1 dose <input type="checkbox"/> Maintenance: 20 mg/kg ( _____ mg) IV every 3 weeks x 7 doses, beginning 3 weeks after initial dose
<b>Administration</b>	<input checked="" type="checkbox"/> Reconstitute vial(s) and dilute per manufacturer guidelines. For doses <1800 mg use a 100 mL bag of NS. For doses ≥1800 mg use a 250 mL bag of NS (remove equal volume first) <input checked="" type="checkbox"/> Infuse first 2 infusions over 90 min, may infuse subsequent infusions over 60 min if well tolerated
<b>Quantity / Refills</b>	Dispense 3 week supply of all selected medications Refill x 7 (or quantity sufficient to complete a total of 8 Tepezza infusions) Other: _____ Dispense all medical supplies necessary for infusion

## 5. Additional Orders

☒ RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per Coastal Infusion Services Policy and Procedure  
☒ RN to instruct patient to hydrate pre/post infusion and educate on taking OTC diphenhydramine and/or acetaminophen per manufacturer dosing recommendations as needed to prevent/treat post-infusion headache.  
☒ RN to monitor patient for minimum of 30 min post infusion. RN to educate patient on possible side effects, allergic reactions, and when to contact physician  
☐ Other: \_\_\_\_\_

## 6. Adverse Reaction Orders

In the event an infusion reaction occurs:  
☒ Interrupt or slow the rate of infusion and use appropriate medical management  
☒ Notify prescriber. Consideration should be given to pre-medicating and/or infusing subsequent infusions at a slower rate

## 7. Prescriber Information

Prescriber Name: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
License No.: \_\_\_\_\_ DEA NO.: \_\_\_\_\_ NPI: \_\_\_\_\_

\_\_\_\_\_  
Physician Signature (Substitution Permitted)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature (Dispense as Written)

\_\_\_\_\_  
Date

By signing I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment. Coastal Infusion Services has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.

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