COASTAL INFUSION SERVICES

1922 Highway 22 W, Suite A
Madisonville, LA 70447
Local: 985-792-9001

Toll-Free: 833-285-5500
Fax: 985-792-9004
Toll-Free: 833-235-1686

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

Medication	**Tepezza 500mg vial**
Dosing / Frequency	☐ Initial dose: 10 mg/kg (_____ mg) IV x 1 dose ☐ Maintenance: 20 mg/kg (_____ mg) IV every 3 weeks x 7 doses, beginning 3 weeks after initial dose
Administration	☒ 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) ☒ Infuse first 2 infusions over 90 min, may infuse subsequent infusions over 60 min if well tolerated
Quantity / Refills	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.