Tepezza Order Form
(teprotumumab-trbw)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

☐ E05.00 Thyrotoxicosis with Diffuse Goiter without Thyrotoxic Crisis or Storm

Other: _____

Prescribing Information

Patient with pre-existing diabetes should be under appropriate glycemic control before receiving Tepezza

***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-Medications

☐ Cetirizine: 10 mg PO
☐ Diphenhydramine: 25 mg PO
☐ Diphenhydramine: 25 mg IVP
☐ Methylprednisolone: 125 mg SIVP
Other: _____

TEPEZZA (teprotumumab-trbw)

Total volume of 100 mL of 0.9% Sodium Chloride for doses <1800 mg or 250 mL for doses ≥1800 mg

Loading Dose

☐ **IV:** Infuse 10 mg/kg as a single dose over 1 hour and 30 minutes

Maintenance Dose

☐ **IV:** Infuse 20 mg/kg as a single dose over 1 hour and 30 minutes every 3 weeks for 7 infusions (infusions 3-7 over 60 minutes, if tolerated)

Patient Weight: _____ lbs **or** _____ kg

Post Treatment Observations: The patient is observed for 30 minutes following the first administration.

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Comments:

_____

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____