

Patient Name: _____

DOB: _____ Wt(kg): _____

Allergies: _____ Phone: _____

TEPEZZA (teprotumumab-trbw) Infusion Orders

Required Information:

Signed order from prescribing provider
Patient demographics including insurance information
Supporting clinical documentation: Visit notes, diagnostic results
Clinical Activity Score _____ 0-10 scale (Please attach CAS form)
Required Labs: TSH, T3, and Free T4

Primary Diagnosis:

Thyroid Eye Disease (TED) (ICD-10 : _____)

Other: _____ (ICD-10: _____)

TEPEZZA ORDERS

Induction Dose: Infuse 10 mg/kg as a single dose over 1 hour and 30 minutes

Maintenance Doses: 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)

Administered per manufacturer guidelines over 90 minutes

PRE-MEDICATIONS

PO Tylenol _____ mg

PO Cetirizine _____ mg

IV Solu-medrol _____ mg

PO Loratadine _____ mg

PO IV Diphenhydramine _____ mg

PO IV Other: _____ mg

LABS

CBC

ESR

TSH, T3, and T4

Frequency:

Every Visit

CMP

TB Quantiferon Gold

Blood glucose

Every Other Visit

CRP

Hep B Core/Surface AG

Other: _____

One time only

Other: _____

CPL Acct #: _____

ADDITIONAL INSTUCTIONS

Please include accommodations to be made for the patient, catheter care, prn orders, etc.

Physician Name:

Phone:

Fax:

Physician Signature:

NPI:

Date: