Teprotumumab-trbw (Tepezza)

Provider Order Form rev. 01/02/2024

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Thyroid Eye Disease:

Other: Description:

THERAPY ADMINISTRATION & DOSING

☑ Administer Teprotumumab-trbw (Tepezza) intravenously in 0.9% sodium chloride:

- **First infusion:** 10 mg/kg IV x (current weight) _____ kg = _____ mg x 1 dose
- **Subsequent (Infusions 2-8):** 20mg/kg IV x (current weight) _____ kg = _____ mg x7 doses

☑ No POC glucose testing or pregnancy testing will be performed in infusion clinic

☑ Doses up to 1800mg mix in NS to final volume of 100ml. Doses greater than 1800mg, mix in NS 250ml

☑ Infuse over 90 mins for the first 2 doses. If patient tolerates well, all future infusions can infuse over 60mins

FREQUENCY *(Choose one)*

☐ Every 3 weeks (8 infusions total)

☐ Every _____ weeks

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

☐ Loratadine 10mg PO

☐ Tylenol 500mg PO

☐ Solumedrol ☐ 40mg/ ☐ 125mg IVP

☐ Benadryl ☐ 25 mg / ☐ 50mg ☐ PO / ☐ IV

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Abnormal vital signs or chance of pregnancy
- Worsening IBD
- Signs/symptoms of hyperglycemia (increased thirst, headaches, blurred vision, frequent urination, weight loss, dry mouth, confusion, SOB, sweet-smelling breath)
- Planned/recent surgical procedures, recent live vaccinations, or neurological changes

☑ Assess patients' hearing before, during and after treatment with Tepezza and report any changes to ordering provider

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, Lid retraction in mm, soft tissue involvement, Exophthalmos in mm, diplopia, eye pain, proptosis, CAS score sheet, history of steroid use.

Required Labs: T3 and T4

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.