Teprotumumab-trbw (Tepezza)

Provider Order Form rev. 09/19/2024

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: ☐ E05.00: Thyrotoxicosis with diffuse goiter

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, include in history ***(please reference specific payor policy guidelines)***: Lid retraction in mm, soft tissue involvement, Exophthalmos in mm, diplopia, eye pain, proptosis, history of steroid use and CAS scores

Required Labs: Thyroid Panel with TSH (including Free T3 and T4 levels)

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.