

Teprotumumab-trbw (Tepezza)

Provider Order Form rev. 04/14/2026

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: _____

Does patient have an Endocrinologist: No Yes (If Yes): Provider Name: _____

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.