Boca Raton
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Boca Raton, FL 33428

ThrIVewell™
INFUSION
Office: 212-803-3339 Fax : 646-768-8600

TEPEZZA INFUSION ORDERS *Date:* _____

Note: This form is being provided as a guide. Prescribers should use their clinical judgment when completing. Some facilities prefer to use their own infusion order form. Check with your patient's facility before writing your infusion order.

PATIENT INFORMATION

Name:	DOB:	Sex: M☐ F☐	Weight: kilo☐ lb☐
Phone number:	Email:		
Allergies:	ICD-10 code:		
Is the patient diabetic? Yes☐ No☐	Does the patient have a history of IBD? Yes☐ No☐		
Emergency contact name:	Phone number:		

Please attach: 1. List of current medications, 2. Copy of the patient's insurance card, 3. Clinical progress notes and history and physical (H&P) to support diagnosis, and 4. Relevant labs.

PHYSICIAN INFORMATION

Prescribing Physician's Name:	Practice Name:
Phone Number:	Fax Number:
Email:	Office Contact:
Co-managing Physician Name:	Phone Number/Email:

MEDICATION ORDER

Medication: TEPEZZA (teprotumumab-trbw)
Dose: Infusion 1: mg (10 mg/kg) Infusions 2 to 8: (20 mg/kg)
Duration: Administer the first 2 infusions over 90 minutes. Subsequent infusions may be reduced to 60 minutes if well tolerated (see note below for additional information).
Saline bag: Administer via an infusion bag containing 0.9% Sodium Chloride Solution, USP. For doses <1800 mg, use a100-mL bag. For doses 1800 mg, use a 250-mL bag.

Schedule: Q3 weeks, 8 infusions total

Preferred start date:_____

Pretreatment medications:

Note: TEPEZZA does not require a specific protocol for premedications; follow your facility protocol. If the patient experiences an infusion reaction, consider premedication for subsequent doses (see note below for additional information).

Notes:

- ☐ If an infusion reaction occurs, interrupt or slow the rate of infusion and use appropriate medical management. For subsequent infusions, slow infusion to 90 minutes and consider premedicating with an antihistamine, antipyretic, and/or corticosteroid.
- ☐ Follow your facility protocol and notify the prescriber. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting, and/or dressing changes.
- ☐ Share post-infusion chart notes with the prescriber.
- ☐ Other notes:

LAB ORDERS

Standing Labs:

- Blood glucose test every_____ infusion(s)
- Other labs (e.g. thyroid, pregnancy):_____
  - ☐ Share lab results with co-managing physician.

Physician signature: _____
If using this as an order form, must fill out with signature.

Please see Important Safety Information on next page and accompanying Full Prescribing Information.

INSURANCE INFORMATION

☐ Request priror authorization support (please sned digital documentation)

Primary Insurance _____ Insurance Company _____

Policy # _____

Policyholder's first and last name _____ Policyholder's DOB: _____ (MM/DD/YYYY)

Second Insurance _____ Policy #/ Group # _____