Connecticut 500 W Putnam Ave Ste 435 Greenwich, CT 06830





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 \Box No \Box	Does the patient have a history of IBD? Yes \Box No \Box		
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	Pretreatment medications:		
Preferred start date:	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):	- anving Full Prescribing Information.		
INSURANCE INFORMATION			
Request priror authorization support			
Primary Insurance	(please sned digital documentation) Insurance Company		
Policy #			
Policyholder's first and last name	Policyholder's DOB: Policyholder's first and last name (MM/DD/YYYY)		
Second Insurance	Policy #/ Group #		