Borough Park
1428 36th Street
Suite 107
Brooklyn, NY 11218

Forest Hills
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

Sheepshead Bay
2546 East 17th Street
Fl, 1
Brooklyn, NY 11235

Long Island City
36-36 33rd
Suite 311
Long Island City, NY 11106

Bronx
226 West 238th Street
Bronx, NY 10463

Massapequa
97 Grand Avenue
Massapequa, NY 11758

NYC

E 56th & Park Midtown
120 East 56 Street
Suite 300
New York, NY 10022

FIDI
30 Broad Street
Suite 401
New York, NY 10004

Gramercy
7 Gramercy Park West
Lower Level
New York, NY, 10003

E 70th St Upper East Side
225 E 70th Street
Suite 1E
New York, NY 10021

Central Park West
115 Central Park West
Suite 15
New York, NY 10023

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

Mission Medical

Tarrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523

Port Jefferson
12 Medical Drive
Suite B
Port Jefferson Station, NY 11776

Staten Island
27 New Dorp Lane
Staten Island, NY 10306

Southampton
625 Hampton Road
Southampton, NY 11968

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

Holbrook
233 Union Avenue
Suite 207
Holbrook, NY 11741

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

Rockville Centre
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

New Hyde Park
1991 Marcus Ave
Suite 110
Lake Success, NY, 11042

Woodbury
7600 Jericho Tpke,
Lower Level, Suite C500
Woodbury NY 11797

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 # _____