

TN
100 Covey Drive
Suite 307
Franklin, TN 37067

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 <input type="checkbox"/> F <input type="checkbox"/>	Weight: kilo <input type="checkbox"/> lb <input type="checkbox"/>
Phone number:	Email:		
Allergies:	ICD-10 code:		
Is the patient diabetic? Yes <input type="checkbox"/> No <input type="checkbox"/>	Does the patient have a history of IBD? Yes <input type="checkbox"/> No <input type="checkbox"/>		
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 a 100-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).
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Notes: <input type="checkbox"/> 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. <input type="checkbox"/> 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. <input type="checkbox"/> Share post-infusion chart notes with the prescriber. <input type="checkbox"/> Other notes:

LAB ORDERS
Standing Labs: <ul style="list-style-type: none">• Blood glucose test every _____ infusion(s)• Other labs (e.g. thyroid, pregnancy): _____ <input type="checkbox"/> 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	
<input type="checkbox"/> Request prior authorization support (please send digital documentation)	
Primary Insurance _____	Insurance Company _____
Policy # _____	Policyholder's DOB: _____ (MM/DD/YYYY)
Policyholder's first and last name _____	_____
Second Insurance _____	Policy #/ Group # _____