ALLIED INFUSION SERVICES

TEPEZZA (teprotumumab-trbw) Infusion Orders

Phone: 713-222-2364 or 1-888-538-0060
Fax: 832-698-3961

Patient Information

Name: ______________________
DOB: ______________________
Address: ______________________
City: __________ State: __________
Zip: __________ Weight: __________
Phone: ______________________
Allergies: ______________________

Prescriber Information

Prescriber Name: ______________________
NPI: ______________________
Address: ______________________
City: ______________________
State: __________ Zip: __________
Phone: ______________________

Diagnosis (please provide ICD-10 code in space provided):

________ Thyroid Eye Disease ________ Other: ______________________

Nursing Orders: Hold infusion and notify provider for:

o Abnormal vital signs or chance of pregnancy o Worsening IBD o Signs/symptoms of hyperglycemia (increased thirst, headaches, blurred vision, frequent urination, weight loss, dry mouth, confusion, SOB, sweet-smelling breath) *No POC glucose testing will be performed in infusion clinic* *No POC pregnancy testing will be performed in infusion clinic*

Premedications:

☐ Tylenol 650mg PO ☐ Benadryl 25mg IV or PO ☐ Solu-Medrol IV 40mg. 125mg or ____ mg
☐ Other: ______________________IV or PO

Order valid for one year unless otherwise indicated. IV solutions and diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Monitor for hearing loss, assess hearing impairment

☐ First Dose: Administer TEPEZZA 10 mg/kg x (current weight) ____________ kg = __________ mg x 1 dose

☐ Subsequent Doses (2-8): TEPEZZA 20mg/kg x (current weight) ____________kg = __________ mg x 7 doses

Doses up to 1800mg mix in NS to final volume of 100ml. Doses greater than 1800mg, mix in NS 250ml. Infuse over 90 minutes for the first 2 doses. If patient tolerates well, all future infusions can infuse over 60 minutes.

Prescriber Name (Please print): ______________________
Prescriber Signature: ______________________ Date: ______________________

Please include a copy of the latest insurance information as well as all applicable clinical notes.

Email to: orders@alliedinfusion.com Fax to: 832-698-3961

By signing this form, you certify that the use of the selected treatment is medically necessary and you will be supervising the treatment of the patient. Additionally, you authorize Allied Infusion Services to act as your prior authorization designated agent when interacting with medical and prescription payors and patient assistance programs.