

TEPEZZA® (TEPROTUMUMAB-TRBW) PRESCRIBER ORDER FORM

FAX COMPLETED FORM, INSURANCE INFORMATION, CLINICAL DOCUMENTATION (LATEST NOTES & LABS) to: (757) 466-1128

☐ **NEW PATIENT** OR

☐ **CHANGE ORDER:** ☐ Drug Change ☐ Dose Change ☐ Interval Change

Patient Name: _____ Date of Birth: _____

Phone: _____ Gender: _____

Address: _____

Allergies: _____

Height: ☐ in ☐ cm Weight: ☐ lbs ☐ kg

CLINICAL INFORMATION

Primary Diagnosis Description: Thyroid eye disease ICD-10 Code: E05.00

PRESCRIPTION

Tepezza® (Teprotumumab-trbw)

VOA MSIC to initiate services beginning with Dose No. _____ as indicated below.

Dose 1: Infuse 10mg/kg IV over 90 minutes, then 3 weeks later...

Dose 2: Infuse 20mg/kg IV over 90 minutes, then 3 weeks later...

Dose 3 through 8: Infuse 20mg/kg IV over 60 to 90 minutes (as tolerated by patient) every 3 weeks x 6 doses.

Dispense quantity sufficient of Tepezza® 500mg single dose vials for each dose.

Withdraw calculated dose from vial and discard any unused vial contents.

ANCILLARY ORDERS

Pre-Medication Orders

☐ Acetaminophen 650mg PO 30 minutes before infusion. *Patient may decline.*

☐ Diphenhydramine 25mg PO 30 minutes before infusion. *Patient may decline.*

☐ Cetirizine 10mg IV 30 minutes before infusion. *Patient may decline.*

☐ Other: _____

IV Flush Orders

☐ Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.

☐ Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw.

PRN Hypersensitivity Meds:

- Epinephrine 0.3mg
- Solu-Cortef 100mg
- Solu-Medrol 125mg
- Diphenhydramine 25-50mg
- NS 500 ML (>30kg)

Refill above ancillary orders as directed x 1 year.

VOA MSIC is a provider led infusion clinic and will utilize VOA infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____

Date: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____ Fax: _____

Address: _____ NPI: _____

City, State, Zip: _____ Office Contact: _____

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. **IMPORTANT WARNING:** This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of the information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.