

<b>TEPEZZA® (TEPROTUMUMAB-TRBW) PRESCRIBER ORDER FORM</b>		
<b>FAX COMPLETED FORM, INSURANCE INFORMATION, CLINICAL DOCUMENTATION (LATEST NOTES &amp; LABS) to: (757) 466-1128</b>		
<input type="checkbox"/> <b>NEW PATIENT</b> <input type="checkbox"/> <b>CHANGE ORDER:</b> <input type="radio"/> <b>Drug Change</b> <input type="radio"/> <b>Dose Change</b> <input type="radio"/> <b>Interval Change</b>		
Patient Name:	Date of Birth:	
Phone:	Gender:	
Address:		
Allergies:		
Height: <input type="checkbox"/> in <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs <input type="checkbox"/> kg	
<b>CLINICAL INFORMATION</b>		
<b>Primary Diagnosis Description:</b> Thyroid eye disease	<b>ICD-10 Code:</b> E05.00	
<b>PRESCRIPTION</b>		
<b>Tepezza® (Teprotumumab-trbw)</b> 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.		
<b>ANCILLARY ORDERS</b>		
<b>Pre-Medication Orders</b> <input type="checkbox"/> Acetaminophen 650mg PO 30 minutes before infusion. <i>Patient may decline.</i> <input type="checkbox"/> Diphenhydramine 25mg PO 30 minutes before infusion. <i>Patient may decline.</i> <input type="checkbox"/> Cetirizine 10mg IV 30 minutes before infusion. <i>Patient may decline.</i> <input type="checkbox"/> Other: _____		
<b>IV Flush Orders</b> <input type="checkbox"/> <u>Peripheral:</u> 0.9% Sodium Chloride 2 to 3 mL pre-/post-use. <input type="checkbox"/> <u>Implanted Port:</u> 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw.		
<b>PRN Hypersensitivity Meds:</b> <ul style="list-style-type: none"> <li>• Epinephrine 0.3mg</li> <li>• Solu-Cortef 100mg</li> <li>• Solu-Medrol 125mg</li> <li>• Diphenhydramine 25-50mg</li> <li>• NS 500 ML (&gt;30kg)</li> </ul>		
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>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>		
<b>Prescriber Signature:</b>	<b>Date:</b>	
<b>PRESCRIBER INFORMATION</b>		
<b>Prescriber Name:</b>	<b>Phone:</b>	<b>Fax:</b>
<b>Address:</b>	<b>NPI:</b>	
<b>City, State, Zip:</b>	<b>Office Contact:</b>	
<small>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. <b>IMPORTANT WARNING:</b> 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.</small>		