Virginia Oncology Associates
MSIC
Multispecialty Infusion Clinic

(757) 271-0969 call
(757) 466-1128 fax

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:**	