



# Tepezza (Teprotumumab-trbw) Infusion Order Form

### Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ M  F

Allergies: \_\_\_\_\_

New Treatment     Continuing Treatment    Last Treatment Date: \_\_\_\_\_    Next Due Date: \_\_\_\_\_

### Diagnosis and ICD 10 Code (Required)

Thyroid Eye Disease    ICD 10 Code: E05.00

### Required Tests

Clinical Activity Score (CAS) (attach results)  
Pregnancy Test Status & Date: \_\_\_\_\_

### Required Labs

Most recent CBC & CMP (attach results)  
Thyroid Panel (within 3 months & attach results)

### Pre-Medication Orders

Acetaminophen (Tylenol)     500mg     650mg     1000mg     PO  
Diphenhydramine (Benadryl)     25mg     50mg     PO     IV  
Methylprednisolone (Solu-Medrol)     125mg     IV  
Ondansetron (Zofran)     4mg     8mg     PO     IV  
Other: \_\_\_\_\_ Route: \_\_\_\_\_  
Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

### Nursing

Provide nursing care per Smart Infusion Nursing Procedures,  
Including reaction management and post-procedure observation.

### Special Instructions / Notes

**Tepezza Medication Order**

**Patient Weight:** \_\_\_\_\_ KG

Dosage

10mg/kg IV for the initial infusion  
 20mg/kg IV every 3 weeks x 7 doses

Other  
Frequency: \_\_\_\_\_

**Required Documents**

Patient Demographic Sheet  
 H & P within the past 6 months  
 Current Medication List  
 Clinical & Progress Notes (including last infusion note)  
 Copy of Insurance Card (Front/Back)

**Location**

Eau Claire     Weston     Middleton

### Provider Information

Provider Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_