**Tepezza** (Teprotumumab-trbw)
Infusion Order Form

**Location**
☐ Eau Claire     ☐ Weston
☐ Middleton      ☐ Onalaska

## 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  ☐ 1000m  PO

Diphenhydramine (Benadryl)     ☐ 25mg  ☐ 50mg  ☐ PO  ☐ IV
Methylprednisolone (Solu-Medrol)     ☐ 125mg   IV

Ondansetron (Zofran)     ☐ 4mg  ☐ 8mg  ☐ PO  ☐ IV

Other: _____ Route: _____

Dose: _____Frequency: _____

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**Tepezza Medication Order**

**Refill x12 months unless otherwise noted: _____**

**Patient Weight**: _____ KG

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

☐ Other

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**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)

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### Adverse Reaction Management & Nursing Orders

Full protocols are available for review at mysmartinfusion.com or upon request.

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|---|---|
| ☒ Administer the following emergency medications per Smart Infusion Therapy Services protocol:<br>  ☒ Acetaminophen 650mg PO,<br>  ☒ Diphenhydramine 25mg-50mg PO or IV<br>  ☒ Ondansetron 4mg IV<br>  ☒ Sodium Chloride 0.9% 1000mL IV<br>  ☒ Methylprednisolone 125mg IV<br>  ☒ Albuterol Sulfate 2.5mg nebulized<br>  ☒ Oxygen 1-6LPM continuous flow<br>  ☒ Epinephrine 0.3mg/0.3mL IM<br><br>☐ Other: _____ | ☒ Manage  VAD per protocol:<br><br>  ☒ Start/Access and Discontinue PIV/CVC<br><br>  ☒ Flush with NS and/or Heparin per protocol based on line type<br>☒ Other: _____ |

## Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____