

**TEPEZZA® (TEPROTUMUMAB-TRBW) PRESCRIBER ORDER FORM**

Fax completed form, insurance information, and clinical documentation to:



Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Height: \_\_\_\_\_

 inches  cm

Weight: \_\_\_\_\_

 lbs  kg**Clinical Information**

Primary Diagnosis Description: Thyroid eye disease

ICD-10 Code: E05.00

**Tepezza® (Teprotumumab-trbw) Prescription****Tepezza® (Teprotumumab-trbw)**

Option Care Health to initiate services beginning with Dose No. \_\_\_\_\_ as indicated below:

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

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

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

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

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

**Ancillary Orders****Pre-Medication Orders**

- Acetaminophen 650 mg PO 30 min before infusion. Patient may decline.
- Diphenhydramine 25 mg PO 30 min before infusion. Patient may decline.
- Other: \_\_\_\_\_

**IV Flush Orders**

- Peripheral: NS 2 to 3 mL pre-/post-use.
- Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw.  
Heparin (100 unit/mL) 3 to 5 mL post-use.  
For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

**Lab Orders**

- No labs ordered at this time.
- Other: \_\_\_\_\_

Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

*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: \_\_\_\_\_

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