

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

<b>Patient Name:</b>	<b>Date of Birth:</b>	<b>Gender:</b>
<b>Address:</b>		
<b>Phone:</b>	<b>Height:</b>	<input type="checkbox"/> inches <input type="checkbox"/> cm
	<b>Weight:</b>	<input type="checkbox"/> lbs <input type="checkbox"/> kg

**Clinical Information**

<b>Primary Diagnosis Description:</b> Thyroid eye disease	<b>ICD-10 Code:</b> E05.00
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**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****Anaphylaxis Kit**

If this is a 1<sup>st</sup> infusion dose, would you like Option Care Health to provide an anaphylaxis kit with the 1<sup>st</sup> dose?

Yes  No

Dosage:  Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.

Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg – 25mg max dose) IV or IM; repeat x 1 in 15 min PRN no improvement.

0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

**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: 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.  
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.

If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed 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**

<b>Prescriber Name:</b>	<b>Phone:</b>	<b>Fax:</b>
<b>Address:</b>	<b>NPI:</b>	
<b>City, State:</b>	<b>Zip:</b>	<b>Office Contact:</b>

**Fax completed form, insurance information, and clinical documentation to: 713-983-4647**

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