Ph: (888) 209-8874 Fax: (833) 329-4738

Tepezza (teprotumamab-trbw)

Provider Order Form rev. 5/9/2022

PATIENT INFORMATION

Patient Name: DOB:

Patient Phone: Patient Email:

NKDA Allergies: Weight lbs/kg:

Patient Status: New to Therapy Continuing Therapy Therapy Change Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

DOCUMENTATION (REQUIRED)

Labs Insurance Card (front and back) Current Medications History/Progress Notes

ICD-10 CODE

E05.00 Thyroid eye disease

Other: ______________________________

PRE-MEDICATION ORDERS

acetaminophen (Tylenol) 500mg • 650mg 1000mg PO

cetirizine (Zyrtec) 10mg PO

loratadine (Claritin) 10mg PO

diphenhydramine (Benadryl) 25mg 50mg/ PO IV

methylprednisolone (Solu-Medrol) 40mg 125mg IV

hydrocortisone (Solu-Cortef) • 100mg IV

Other: ____

Dose: _________ Route: _____ Frequency: _________________________

MEDICATION ORDER

Tepezza (teprotumamab-trbw)

Dose:

10mg/kg IV for Infusion 1 (given over 90 minutes)

20mg/kg IV for Infusions 2-8 (over 90 minutes for infusion 2; over 60-90 min infusions 3-8)

Frequency:

every 3 weeks for a total of 8 infusions

Order Expiration Date (mm/dd/yy): ____________________
(If not indicated order will expire one year from date signature)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

Check here if this is a stat order