

TEPEZZA® (TEPROTUMUMAB-TRBW) PRESCRIBER ORDER FORM

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**Anaphylaxis Kit**If this is a 1st infusion dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose? Yes NoDosage: 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.

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: _____

Fax completed form, insurance information, and clinical documentation to:**CONFIDENTIAL HEALTH INFORMATION:** Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. **IMPORTANT WARNING:** This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.