PREMIER INFUSION CENTER

📜 Tepezza (teprotumumab-trbw) IV Infusion Order Form

📞 405-442-7577 📠 405-442-7223
📧 orders@premierinfusioncenter.com

👤 Patient Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / _____
- **Phone:** _____ **Email:** _____
- **Address:** _____
- **Weight:** _____ kg **Height:** _____ cm/in
- **Allergies:** ☐ NKDA ☐ _____
- **Treatment Status:** ☐ New ☐ Continued **Last Treatment Date:** ____ / ____ / ____

🔹 Diagnosis (ICD-10 Selection)

☐ E05.00 – Thyrotoxicosis with diffuse goiter without thyrotoxic crisis
☐ H05.20 – Thyroid eye disease, unspecified
☐ Other: _____ **ICD-10 Code:** _____

🔹 Infusion Order

- **Induction Phase:**
  ☐ Infusion 1: 10 mg/kg IV over 90 minutes
  ☐ Infusion 2: 20 mg/kg IV over 90 minutes (3 weeks after first dose)
- **Maintenance Phase:**
  ☐ Infusions 3–8: 20 mg/kg IV every 3 weeks
  ☐ Infuse over 60 minutes if tolerated
- ☐ Dilute in 0.9% sodium chloride:
  ☐ < 1800 mg: 100 mL bag
  ☐ ≥1800 mg: 250 mL bag
- ☐ Flush with 0.9% sodium chloride post-infusion
- ☐ Observation: ☐ 30 minutes post-infusion
- ☐ Refills: ☐ None ☐ 8 infusions ☐ Other: _____

◆ Line Use & Access

☐ Start PIV ☐ Access CVC ☐ Use PICC Line ☐ Flush per standard infusion protocol

◆ Adverse Reaction & Anaphylaxis Orders

☐ Premier Infusion Center Protocol (premierinfusioncenter.com)
☐ Other – please fax preferred reaction orders to 405-442-7223

◆ Premedication (Recommended)

☐ Acetaminophen: ☐ 650 mg ☐ PO
☐ Diphenhydramine: ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
☐ Cetirizine: ☐ 10 mg ☐ PO
☐ Methylprednisolone: ☐ 125 mg ☐ IV
☐ Loratadine: ☐ 10 mg ☐ PO
☐ Other: _____ **Dose:** _____ **Route:** _____

◆ Laboratory Monitoring

☐ CBC ☐ CMP ☐ Blood glucose
☐ Thyroid panel (TSH, T3, T4) ☐ Clinical Activity Score (CAS)
☐ Audiology evaluation (baseline and follow-up)
☐ Other: _____
Frequency: ☐ Prior to first dose ☐ Each infusion ☐ Other: _____
☐ Physician office will order labs only

◆ Clinical Documentation Checklist

☐ Recent progress notes ☐ Last H&P ☐ Lab results ☐ Medication list
☐ Documentation of TED diagnosis and CAS score
☐ Horizon By Your Side enrollment confirmation

◆ Ordering Provider & Demographics

- **Name:** _____
- **NPI:** _____ **License #:** _____
- **Contact:** _____ **Phone:** _____ **Fax:** _____
- **Email:** _____
- **Signature:** _____ **Date:** ____ / _____ / _____