Checklist for Tepezza (teprotumumab-trbw) Referral

Patient Name: _____ DOB: _____ Date: _____

Referring Physician: _____NPI: _____

Office Contact/Title/Email: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

Best contact number for physician in case of reaction: _____

Please return completed checklist and checklist items to initiate referral. Use this form as fax cover sheet.

- ❑ Patient demographic information
- ❑ Insurance information and copy of insurance card/s (front and back). *Include primary and secondary insurance
- ❑ Supporting clinical notes and office visits. Two notes preferred.
    - **See "Clinical documentation of Thyroid Eye Disease (TED) signs and symptoms" to ensure full documentation of disease activity, thyroid function, symptom severity, and therapies tried/failed**
- ❑ Medication list and allergies
- ❑ Supporting lab reports
- ❑ Tepezza Prescribing Order (see attached)

-- We will obtain prior authorization and schedule your patient as soon as possible –

Fax all information to our Infusion Coordinator: 508-698-8671

Call with any questions: 781-551-5812 option 4

Visit our website: www.InfusionCenterNE.com
Email: info@infusioncenterne.com

Infusion Center of New England
9 Payson Road, Suite 100, Foxboro MA 02035
Ph: 781-551-5812
Fax: 508-698-8671

Prescribing Order: Tepezza (teprotumumab-trbw)

Date of Order: _____ ❑ New Start ❑ Maintenance
Date of last infusion: _____

Patient Name: _____ **DOB:** _____ **M/F:** ____

Diagnosis (include ICD-10 code/s): _____

❑ **NKDA** **Allergies:** _____

Patient Weight: _____

Premedication:

❑ Acetaminophen 1000mg PO
❑ Loratadine 10mg or Cetirizine 10mg PO
❑ Diphenhydramine 25mg PO
❑ Diphenhydramine 25mg IV
❑ Solu-medrol 125mg IV
❑ Other: _____

Lab Orders:

❑ POCT Glucose with each infusion.
Notify if >_____mg/dl

❑ POCT pregnancy test with each infusion

Tepezza Medication Order

Infusion 1: ❑ Tepezza 10mg/kg every 3 weeks x1 _____ mg

Infusion 2 - 8: ❑ Tepezza 20mg/kg every 3 weeks x 7 _____ mg

Administration:

- ✓ Reconstitute each TEPEZZA vial with 10 mL of Sterile Water for Injection.
- ✓ Dilute the required volume of reconstituted solution based on the dose in an IV infusion bag containing 0.9% Sodium Chloride Solution. If dose is <1800 mg, use a 100-mL bag. If dose is ≥1800 mg, use a 250-mL bag.
- ✓ Administer infusions 1 and 2 over 90min. If tolerated, remaining infusions can be given over 60min.
- ✓ In case of infusion reaction, STOP infusion and follow ICNE infusion reaction protocol. Notify physician.

Ordering Provider Name **NPI**

Signature **Date**

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