



## 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 --

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

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

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Visit our website: [www.InfusionCenterNE.com](http://www.InfusionCenterNE.com)

Email: [info@infusioncenterne.com](mailto:info@infusioncenterne.com)



### 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.

POCT pregnancy test with each infusion

Notify if > \_\_\_\_\_ mg/dl

### 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.

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Ordering Provider Name

NPI

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Signature

Date