aleracare
advanced home infusion

HOME INFUSION ONLY

FAX 818.390.9697

Tepezza (teprotumamab-trbw)

Provider Order Form rev. 12/23/2024

Patient Information

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

NKDA Allergies: Weight lbs/kg: Height:

Patient Status: New to Therapy Continuing Therapy Therapy Change Last infusion date (if applicable): ____________________

Is the patient pregnant, planning a pregnancy or nursing: Yes No Does the patient need interpreter services: Yes No

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

ICD-10 CODE

E05.00 Thyroid eye disease Other: ____________________

Medication Order

Tepezza (teprotumamab-trbw) **Dose:** 10mg/kg IV (____mg) for Infusion 1 (given over 90 minutes)

20mg/kg IV (____mg) 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

Documentation Required (Note: Send all labs, must include specific labs listed here)

Labs (T3 and T4) Insurance Card (front and back) Current Medications History/Progress Notes

Pre-Medication Order *(given 30 min before each infusion)*

acetaminophen (Tylenol) 500mg 650mg 1000mg PO

diphenhydrAMINE (Benadryl) 25mg 50mg / PO IV

cetirizine (ZyrTEC) 10mg PO

methylPREDNISolone (SOLU-Medrol) 40mg IV 125mg IV

loratadine (Claritin) 10mg PO

hydrocortisone (Solu-CORTEF) 100mg IV

Other: ____________________

Dose:____________________ Route:____________________ Frequency: ____________________

Line/Port Use Orders

RN to start/discontinue peripheral IV or access/de-access port

RN to administer 3-10 mL normal saline with heparin 100 units/mL 1-5 mL per SASH method

Do NOT administer heparin to this patient

Additional orders: ____________________

Adverse Reaction and Anaphylaxis Orders

Standard anaphylaxis kit (EPINEPHrine 0.3 mg IM PRN for severe reactions x 1, may repeat once within 5-15 minutes for a maximum of 2 doses; Benadryl 50 mg PO PRN for mild-moderate reactions x1; Benadryl 50 mg IV PRN for mild-moderate reactions x1)

Additional orders: ____________________

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

Provider Name **Provider Signature** **Date**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

Check here if this is a stat order