ORDERING OFFICE, ALSO FAX:
- Most recent labs- if applicable
- Supporting clinical notes
- Insurance card, front and back

Teprotumumab-trbw (Tepezza)

Provider Order Form

IVX HEALTH formerly Infusion Express

Date:	Patient Name:	DOB:
ICD-10 code (required):		
ICD-10 description:		
☐ NKDA Allergies:		Weight lbs/kg:
Ordering Provider:	Provider NPI:	
Referring Practice Name:	Phone:	Fax:
Practice Address:	City:	State: Zip Code:

NURSING

☑ Provide nursing care per IVX Standard Nursing Procedures, including reaction management and post infusion observation.

LABORATORY ORDERS

☐ CBC ☐ every other dose ☐ every _____
☐ CMP ☐ every other dose ☐ every _____ (CMP includes serum blood glucose)
☐ Other:

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO 30 minutes prior to infusion
☐ cetirizine (Zyrtec) 10mg PO 30 minutes prior to infusion
☐ loratadine (Claritin) 10mg PO 30 minutes prior to infusion
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV prior to infusion
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV 30 minutes prior to infusion
☐ Other:
Dose: Route: Frequency:

INFUSION THERAPY

☑ Teprotumumab-trbw (Tepezza) in 0.9% sodium chloride, intravenous infusion
- Dose: (Please indicate if patient has received any previous doses.)
- 10mg/kg for the first infusion
- 20mg/kg for infusions 2-8
- Frequency: Every 3 weeks, 8 total infusions.
- Administer the first 2 infusions over 90 minutes. Subsequent infusions may be reduced to 60 minutes if well tolerated. If infusion reaction occurs, interrupt or slow the rate of infusion.
- Dilute with 0.9% Sodium Chloride. For doses <1800mg use a 100ml bag. For doses ≥1800mg use a 250ml bag. (Remove equal volume.)

☑ Flush with 0.9% sodium chloride at the completion of infusion
☐ Patient is required to stay for 30-minute observation post infusion*
☐ Patient is NOT required to stay for observation time
☑ Order is valid for 8 total infusions unless otherwise indicated. (Order will expire one year from date signed)

GENERAL PLAN COMMUNICATION

Special instructions/notes:

Ordering Provider: Initial here _____ and proceed to the next page.

REACTION MANAGEMENT

- ☑ Observe for hypersensitivity reaction: Fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation, bronchospasm with or without hypotension or hypertension.
- ☑ If reaction occurs:
  - Stop infusion
  - Maintain/establish vascular access
  - Notify referring provider
  - Consider giving the following PRN
    1. Acetaminophen (Tylenol) 650mg PO **OR**_____mg for pain or fever > 38 C/100.4 F
    2. Diphenhydramine (Benadryl) 25-50mg in 10ml NS slow IV push for rash, itching, pruritis
    3. Ranitidine 25mg in 10ml NS slow IV push over 5 minutes (Consider if patient already given IV Benadryl)
    4. Ondansetron (Zofran) 4mg Slow IV push over 5 minutes for nausea or vomiting.
    5. Methylprednisolone (Solumedrol) 125mg **OR** _____mg slow IV push.
    6. Other _____
  - When symptoms resolve resume infusion at 50% previous rate and increase per manufactures guidelines
  - If symptoms are **rapidly progressing or continue** after administration of prn medications above:
    1. Call 911
    2. Consider giving epinephrine (1:1000 strength) 0.3ml IM for signs symptoms of **severe allergic/anaphylactic reaction** (angioedema, swelling of the mouth, tongue, lips, or airway, trouble breathing, tightness of the throat, low blood pressure). May repeat every 5-15 minutes to a maximum of 3 doses.
    3. Have oxygen by nasal canula available and administer 2-15 liters, titrate to keep Spo2 >92%
    4. Have Automated External Defibrillator available
    5. Notify referring provider. If unable to reach referring provider, notify Local Medical Director.

No premedication required. If the patient experiences an infusion reaction consider premedicating with an antihistamine, antipyretic, and/or corticosteroid.
TEPEZZA may cause an exacerbation of preexisting inflammatory bowel disease (IBD). Monitor patients with IBD for flare of disease.
Hyperglycemia or increased blood glucose may occur in patients treated with TEPEZZA. Monitor patients for elevated blood glucose and symptoms of hyperglycemia while on treatment with TEPEZZA. Patients with pre-existing diabetes should be under appropriate glycemic control before receiving TEPEZZA

Patient Name _____ **Patient Date of Birth** _____

Provider Name (Print) _____

Provider Signature _____ **Date** _____

Designate the desired location and fax the order form to:

KANSAS / MISSOURI fax: (844) 900-1292 | ☐ Overland Park, KS ☐ Lee's Summit, MO ☐ Briarcliff, MO ☐ TBD

OHIO fax: (844) 627-2675 | ☐ Dublin ☐ Pickerington ☐ TBD

PENNSYLVANIA fax: (844) 820-9641 | ☐ Malvern ☐ Bensalem ☐ Montgomeryville ☐ East Shore ☐ West Shore ☐ TBD

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