TEPEZZA Infusion Form

Fax Referral To:
877-438-9380

CONTINUUM Health

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: ____________ Next Infusion Date: ____________

Patient Information

Patient Name: ____________ DOB: ____________ Sex: M F Height: ______ Weight: ____________

Phone Number: ____________ Email Address: ____________

Allergies: ____________ Is the patient Diabetic: Y N ICD-10 Code: ____________

Emergency Contact: ____________ Phone Number: ____________

Please attach the following: 1. List of current Medications, 2. Copy of the patient's Insurance Card, 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs.

Physician Information

Prescribing Physician: ____________ Practice Name: ____________
Practice Phone: ____________ Practice Fax: ____________
Email: ____________ Office Contact: ____________
Co-managing Physician: ____________ Phone/Email: ____________

Medication Order

Medication: *TEPEZZA (teprotumumab-trbw)*

Dose: *Infusion 1: ______ mg (10 mg/kg) Infusions 2 thru 8: ______ mg (20 mg/kg)*

Update patient weight and dose prior to each infusion.

Duration: *Administer the first 2 infusions over 90 minutes. Subsequent infusitons may be reduced to 60 minutes if well tolerated (see note below for additional information).*

Saline bag: *Administer via an infustion bag containing 0.9% Sodium Chloride Solution, USP. For doses <1800 mg, use a 100-ml. bag. For doses >1800 mg, use a 250-ml. bag.*

Schedule: Q3 weeks, 8 infusions total

Preferred start date: ______

Pretreatment medications: No pre-medication required. If the patient experiences an infusion reaction, consider pre-medication for subsequent doses.

Notes:
If an infusion reaction occurs, interrupt or slow the rate of infusion and use appropriate medical management. For subsequent infusions, slow infusions to 90 minutes and consider pre-medicating with an antihistamine, antipyretic, and/or corticosteroid. Follow your facility protocol and Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, de-clotting, and/or dressing changes. Share post-infusion chart notes with the prescriber.

Lab Orders

Standing Labs:

- Blood glucose test every ______ infusion(s)
- Share lab results with co-managing physicians

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

____________ Physician's NPI#

____________ Physician's Address

____________ Prescriber's Signature

____________ Date

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