



159 Fountains Blvd. Madison, MS 39110
Phone: 601.859.8200 Fax: 601.859.8201

**Tepezza
(teprotumumab-trbw)
Order**

****REQUIRED INFORMATION****

- This signed order form from the provider
- Patient demographics & insurance information
- Clinical/Progress Notes, CAS Score (required), TSH, T3, and T4 labs**

Patient Name:	DOB:
Allergies:	Patient Phone:

Pt. Weight _____ kg

Diagnosis:

- Thyroid Eye Disease ICD-1) Code: _____

TEPEZZA ORDERS

First Infusion:

- Tepezza 10mg/kg IV over 90 minutes

Subsequent Infusions:

- Tepezza 20mg/kg IV every 3 weeks after week 0 for 7 doses

Second infusion infuse over 90 minutes, then if tolerated, remaining doses infuse over 60 minutes

Pre-Medication Orders: Tylenol 650mg PO, please choose one antihistamine:

- Cetirizine 10mg PO
- Diphenhydramine 25mg PO
- Loratadine 10mg PO

Does the Patient have a history of Diabetes? Yes No

**Patients with pre-existing diabetes should be under appropriate glycemic control before receiving Tepezza.*

Required labs to be drawn by: Infusion Center Referring Physician

Lab orders: _____ Frequency: _____

Physician Name:	Phone:	Fax:
**Physician Signature:	Date:	