Teprotumumab-trbw (Tepezza)

Provider Order Form rev. 1/8/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Thyroid Eye Disease ☐ E05.00: Thyrotoxicosis with diffuse goiter

Other: Description:

THERAPY ADMINISTRATION & DOSING

☑ Administer Teprotumumab-trbw (Tepezza) intravenously in 0.9% sodium chloride:

- **First infusion:** 10 mg/kg IV x (current weight) _____ kg = _____ mg x 1 dose
- **Subsequent (Infusions 2-8):** 20mg/kg IV x (current weight) _____ kg = _____ mg x7 doses

☑ Doses up to 1800mg mix in NS to final volume of 100ml. Doses greater than 1800mg, mix in NS 250ml

☑ Infuse over 90 mins for the first 2 doses. If patient tolerates well, all future infusions can infuse over 60mins

FREQUENCY *(Choose one)*

☐ Every 3 weeks (8 infusions total)

☐ Every _____ weeks

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every: _____

☐ CMP ☐ at each dose ☐ every: _____

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Loratadine 10mg PO

☐ Tylenol ☐ 500mg / ☐ 650mg PO

☐ Solumedrol ☐ 40mg/ ☐ 125mg IVP

☐ Benadryl ☐ 25 mg / ☐ 50mg ☐ PO / ☐ IV

☐ Other: _____

MONITORING & MANAGEMENT

☑ Hold infusion and notify provider for:

- Abnormal vital signs
- Worsening IBD and changes in hearing
- Signs/symptoms of hyperglycemia
- Planned/recent surgical procedures, recent live vaccinations, or neurological changes

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

Baseline Glycemic Testing and Metabolic Assessment

Has patient completed this testing: ☐ Yes (include results) ☐ No

- If yes (choose one): ☐ Diabetic ☐ Pre-Diabetic ☐ Normal
- ☐ **If Diabetic/Pre-Diabetic:** perform fasting blood glucose test before every infusion and hold infusion if glucose is above:_____mg/dl

☑ Hyperglycemia Assessment Performed prior to each infusion

Pregnancy Urine Test

☐ Patient to complete urine test prior to each infusion and hold infusion if positive result

(Recommended for all patients who meet criteria)

Hearing Assessment and Baseline Audiogram

Has patient completed baseline audiogram: ☐ Yes (include results) ☐ No

- Baseline and follow up audiograms **WILL NOT** be completed by Novella Infusion *(Recommended that all patients receive baseline audiogram prior to 1st infusion with follow up testing at 12 wks, 24 wks and 6 mos.)*

☑ Hearing Assessment performed by Novella Infusion prior to infusion

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, include in history ***(please reference specific payor policy guidelines)***: Lid retraction in mm, soft tissue involvement, Exophthalmos in mm, diplopia, eye pain, proptosis, history of steroid use and CAS scores

Required Labs: Thyroid Panel with TSH (including Free T3 and T4 levels)

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.