

Tepezza (teprotumamab-trbw)

Provider Order Form rev. 5/20/2022



www.vascoinfusion.com
ph: 602-346-0204 fax: 877-637-6691

PATIENT INFORMATION

Patient Name:		DOB:		
Patient Phone:		Patient Email:		
NKDA	Allergies:	Weight lbs/kg:	Height:	
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change	Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip Code:

DOCUMENTATION (REQUIRED)

Labs	Insurance Card (front and back)	Current Medications	History/Progress Notes
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ICD-10 CODE

E05.00 Thyroid eye disease

Other: _____

MEDICATION ORDER

Tepezza (teprotumamab-trbw)

Dose:

10mg/kg IV for Infusion 1 (given over 90 minutes)

20mg/kg IV 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

PRE-MEDICATION ORDERS

acetaminophen (Tylenol) 500mg • 650mg 1000mg PO

cetirizine (Zyrtec) 10mg PO

loratadine (Claritin) 10mg PO

diphenhydramine (Benadryl) 25mg 50mg/ PO IV

methylprednisolone (Solu-Medrol) 40mg 125mg IV

hydrocortisone (Solu-Cortef) • 100mg IV

Other: _____

Dose: _____ Route: _____ Frequency: _____

Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date signature)

SPECIAL INSTRUCTIONS

Provider Name (Print)

Provider Signature

Date

Check here if this is a stat order