Tepezza Prescription Order Form

(teprotumumab-trbw)

Fax: 800.540.3400
Phone: 800.540.4700

Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other: _____ Anticipated Start Date: _____

Patient Information

Last Name: _____

First Name: _____

SSN: _____ Date of Birth: _____

Gender: ☐ M ☐ F Height: _____ Weight: _____ ☐ lbs ☐ kg

Allergies: _____

Home #: _____ Alt #: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Guardian/Caregiver: _____

Prescriber Information

Prescriber Name: _____

☐ MD ☐ DO ☐ NP ☐ PA

Practice Name: _____

Address: _____

City: _____ State: _____ Zip: _____

License #: _____ NPI: _____ DEA#: _____

Phone: _____ Fax: _____

Contact Name: _____ Phone: _____

Collaborating Physician: _____

PLEASE ATTACH COPIES OF FRONT AND BACK OF PATIENT'S PRESCRIPTION INSURANCE CARDS

Clinical Information

Primary Diagnosis: Date of TED Diagnosis: _____

☐ E05.00 – Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm (hyperthyroidism)

☐ Other (ICD-10 and Description): _____

Pre Meds

☐ Normal Saline 0.9% 500ml IV with Tepezza infusion PRN

☐ Other: _____

_____

Prescription Information

Tepezza: 500mg/vial for Intravenous Use
Duration: Infusion every 3 weeks for a total of 8 infusions. Administer the first two infusions over 90 minutes. Subsequent infusions may be reduced to 60 minutes if well tolerated.

Dose:

Week 0 (10mg/kg):

Tepezza _____mg/_____ml NS

Reconstitute each Tepezza 500mg vial with 10ml Sterile Water. Discard _____ml NS from NS bag. Withdraw and add _____ml (_____mg) Tepezza to NS bag. Infuse _____mg IV once over 90 minutes x1dose.

Duration: 1 dose, 21 days supply, no refills

Week 3 (20mg/kg):

Tepezza _____mg/_____ml NS

Reconstitute each Tepezza 500mg vial with 10ml Sterile Water. Discard _____ml NS from NS bag. Withdraw and add _____ml (_____mg) Tepezza to NS bag. Infuse _____mg IV every 3 weeks over 90 minutes x7doses. Subsequent infusions may be reduced to 60 minutes if well tolerated.

Duration: total of 7 doses every 3 weeks, 6 refills

☐ Dispense anaphylaxis kit PRN for infusion reaction.
Kit contains the following (1 each):

- ✓ Diphenhydramine 25mg cap
- ✓ Diphenhydramine 50mg/ml
- ✓ Solumedrol 125mg vial
- ✓ 0.9% NaCL 500ml Bag
- ✓ Zofran 4mg vial IVP
- ✓ Epinephrine pen: Inject IM/SQ into outer thigh PRN allergic reaction, including anaphylaxis

- Skilled Nursing Visits needed to establish venous access, provide education, administer medication, and assess general status and response to therapy
- Infusion to be administered by pump or regulated dial a flow
- Supplies are necessary to administer therapy

Is this the first dose? ☐ Yes ☐ No. If no, date first dose given: _____ and next dose to be given: _____

Infusion reaction: Per Polaris Patient Infusion Reaction policy

Access: ☐ Peripheral ☐ PICC ☐ Port ☐ Other: _____

Flushing: Polaris Pharmacy Guidelines (heparin 10-100u/ml, 0.9% NaCL and/or D5W flushes PRN to establish and maintain IV access

Prescriber Signature

(Prescriber, please sign and date below)

No stamps. Signature and date must be completed in prescriber s handwriting.
NY prescriptions must be submitted via e script

I authorize Polaris Specialty Pharmacy and its representatives to act as an agent to initiate and execute prior authorization for the above patient in order to expedite the process, please provide chart notes and most recent labs.

Physician's Signature: _____ ☐ **Dispense as written (DAW) Date:** _____/_____/_____