Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Tepezza® (teprotumumab-trbw) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:			Patient's Phone:		
Patient Name:			Address:		
Date of Birth:			City, State, Zip:		
Height in inches:	Weight: LB or KG		Gender:	Allergies:	☐ See list ☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	E05.00 - Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm
☐	_____ - Other:

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5			☐ **Continue current order until insurance approved**
6			

MEDICATION ORDERS:

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMNISTRATION AS SELECTED

IV	Diphenhydramine	◯	25mg	◯	50mg				
	Methylprednisolone	◯	40mg	◯	125mg	◯	Other:		
	Famotidine	◯	20mg	◯	40 mg				
	Other:	◯							

PO	Acetaminophen	◯	325mg	◯	500mg	◯	650mg	◯	1000mg
	Famotidine	◯	20mg	◯	40mg				
	Diphenhydramine	◯	25mg	◯	50mg				
	Fexofenadine	◯	60mg	◯	180mg				
	Cetirizine	◯	10mg						
	Loratadine	◯	10mg						
	Other:	◯							

MEDICATION:

☑ Tepezza® (teprotumumab-trbw) diluted in 100--250ml NS

DOSE:

◯ Initial dose: Intravenous infusion of 10 mg/kg

Infusion #1 infused over 90 minutes

◯ Subsequent dose: Intravenous infusion of 20 mg/kg every three weeks for 7 more infusions.

Infusion #2 infused over 90 minutes

Infusion #3-8 infused over 60 minutes

◯ Other:_____

SPECIAL/LAB ORDERS:

◯ _____

_____

☑ Refills:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	