

# TEPEZZA (teprotumamab-trbw)

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Status:  New to therapy  Continuing  Next Due Date (if applicable)

## PROVIDER INFORMATION

Provider Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_  
 Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Practice Name: \_\_\_\_\_  
 Practice Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_

## MEDICAL INFORMATION

Patient Weight: \_\_\_\_\_ Patient Height: \_\_\_\_\_ ICD-10 Code (required): \_\_\_\_\_ ICD-10 Description: \_\_\_\_\_  
 Known Allergies: \_\_\_\_\_

**Required Labs:** TSH, T3, T4, TH

## DETAILS NEEDED FOR AUTHORIZATION

- Proof of patient being concurrently treated with any other biologic: \_\_\_\_\_
- CAS Score \_\_\_\_\_ 0-10 scale (**required**)
- If history of diabetes, glucose is under control

## TEPEZZA (teprotumumab-trbw) ORDERS

10mg/kg IV for first infusion, followed by 20mg/kg IV every 3 weeks for 7 additional infusions

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

**Additional Orders/Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## ADULT RESCUE MANAGEMENT PROTOCOL

*These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.*

- Following standing reaction orders, including diphenhydramine, methylprednisolone, albuterol, and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

## REQUIRED STANDARD DOCUMENTATION NEEDED

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| <ul style="list-style-type: none"> <li>• Patient demographics</li> <li>• Patient medical insurance card, copied front and back</li> <li>• Patient pharmacy card, copied front and back (if they have one)</li> </ul> | <ul style="list-style-type: none"> <li>• Most recent chart notes and if available, last history and physical. All relevant scans, tests and laboratory results.</li> <li>• If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.</li> </ul> |
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## PROVIDER AUTHORIZATION

Provider's Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_