

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: \_\_\_\_\_ Next Infusion Date: \_\_\_\_\_

Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Allergies: \_\_\_\_\_ Is the patient Diabetic: Y N ICD-10 Code: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Please attach the following: 1. List of current Medications, 2. Copy of the patient's Insurance Card,  
3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs.

Physician Information

Prescribing Physician: \_\_\_\_\_ Practice Name: \_\_\_\_\_  
Practice Phone: \_\_\_\_\_ Practice Fax: \_\_\_\_\_  
Email: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
Co-managing Physician: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

Medication Order

Medication: TEPEZZA (teprotumumab-trbw)

Dose: Infusion 1: \_\_\_\_\_ mg (10 mg/kg) Infusions 2 thru 8: \_\_\_\_\_ mg (20 mg/kg)

Update patient weight and dose prior to each infusion.

Duration: Administer the first 2 infusions over 90 minutes. Subsequent infusions may be reduced to 60 minutes if well tolerated (see note below for additional information).

Saline bag: Administer via an infusion bag containing 0.9% Sodium Chloride Solution, USP. For doses <1800 mg, use a 100-ml. bag. For doses >1800 mg, use a 250-ml. bag.

Schedule: Q3 weeks, 8 infusions total

Preferred start date: \_\_\_\_\_

Pretreatment medications: No pre-medication required. If the patient experiences an infusion reaction, consider pre-medication for subsequent doses.

Notes:

If an infusion reaction occurs, interrupt or slow the rate of infusion and use appropriate medical management. For subsequent infusions, slow infusions to 90 minutes and consider pre-medicating with an antihistamine, antipyretic, and/or corticosteroid. Follow your facility protocol and Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, de-clotting, and/or dressing changes. Share post-infusion chart notes with the prescriber.

Lab Orders

Standing Labs:

- Blood glucose test every \_\_\_\_\_ infusion(s)
- Share lab results with co-managing physicians

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing ContinuumRx to serve as my prior authorization agent with medical and pharmacy insurance providers.

\_\_\_\_\_  
Physician's NPI# Physician's Address  
\_\_\_\_\_  
Prescriber's Signature Date