

Teprotumumab-trbw (Tepezza)

Provider Order Form rev. 8/23/26



PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____ Mobile Phone Number: _____
Weight (lbs/kg): ☐ NKDA Allergies: _____
Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

REQUIRED SUPPORTING DOCUMENTATION (Please include the following with the order to support processing & insurance approval)

- Patient demographics
- Office/progress notes supporting diagnosis including treatment failures
- Labs & tests supporting diagnosis
- Insurance card(s)
- Recent Thyroid Panel
- CAS Score

DIAGNOSIS ICD-10 CODE (Provider must specify)

- | | |
|---|---|
| ☐ E05.00 Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm | ☐ H05.833 Thyroid orbitopathy, bilateral |
| ☐ H05.831 Thyroid orbitopathy, right orbit | ☐ H05.839 Thyroid orbitopathy, unspecified orbit |
| ☐ H05.832 Thyroid orbitopathy, left orbit | |
| ☐ Other: _____ | |

PRIMARY MEDICATION ORDER

Teprotumumab-trbw (Tepezza) in 0.9% sodium chloride intravenous infusion

- Dilute with 0.9% Sodium Chloride. For doses <1800mg use a 100ml bag. For doses ≥1800mg use a 250ml bag. (Remove equal volume.)
- Administer the first 2 infusions over 90min. Subsequent infusions may be reduced to 60min if well tolerated. If reaction occurs, interrupt or slow the rate of infusion.
- Patients with pre-existing diabetes should be under appropriate glycemic control before receiving Tepezza
- ☐ Patient is required to stay for 30-minute observation
- Order valid for one year unless otherwise noted: _____

Dose / Frequency:

- ☐ Tepezza 10mg/kg IV once followed by 20mg/kg IV every 3 weeks for seven additional treatments
- ☐ Other: _____

PRE-MEDICATION

Note: pre-meds not typically indicated for Tepezza

- ☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
- ☐ cetirizine (Zyrtec) 10mg PO
- ☐ loratadine (Claritin) 10mg PO
- ☐ famotidine (Pepcid) 20 mg IV
- ☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
- ☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
- ☐ Other: _____
Dose: _____ Route: _____

LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every _____
- ☐ CMP ☐ at each dose ☐ every _____
- ☐ Other: _____

NURSING

- Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

SPECIAL INSTRUCTIONS

Ordering Provider (Print)

Provider Signature

Provider NPI

Date

- ☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: _____	Referral Coordinator Email: _____
Referring Practice Name: _____	Phone: _____ Fax: _____
Practice Address: _____	City: _____ State: _____ Zipcode: _____

ARBOR INFUSION FAX NUMBERS (Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)

- ☐ Arbor Infusion Fishers (317) 981-1772