Conveniently Located in East Syracuse, Onondaga Hill & Auburn
Main Office Phone 315-472-7504
Nurse Navigator Phone 315-506-2469
Main Fax 315-634-5168

Tepezza (teprotumumab-trbw) Non-Oncology Treatment Order Set

1. Patient Name: _____

2. DOB: _____ **Height (inches):** _____ **Weight (lbs):** _____

3. Diagnosis:

[ ] E05.00 Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm
[ ] Other ICD-10 Code: _____ Diagnosis description: _____

4. Pre-medications:

[ ] Acetaminophen: [ ] **1000mg PO** [ ] **500mg PO**
[ ] Diphenhydramine: [ ] **25mg PO** [ ] **50mg PO** [ ] **25mg IV** [ ] **50mg IV**
[ ] Dexamethasone: 10mg IV
[ ] Hydrocortisone: 100mg IVP
[ ] Other Pre-medication: _____
[ ] No Pre-medications indicated

5. Drug Order:

Tepezza (teprotumumab-trbw) *Ok to substitute with generic/biosimilar*
Initial dose 10mg/kg IV one time, then 20mg/kg IV every 3 weeks for 7 doses (total of 8 infusion to be given)
Special Instructions: _____
[ ] New to Therapy
[ ] Continuing therapy: Last Dose Received _____ Next Dose Due _____

HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral

6. Infusion Lab Requirements:

[ ] HOA RN to obtain Glucose Finger stick DAY OF INFUSION; hold therapy for result >250 & notify prescriber before proceeding
[ ] NO glucose finger stick monitoring by HOA RN needed prior to infusion
[ ] CBC & CMP within 2 weeks prior to infusion
[ ] Other: _____
[ ] No lab monitoring indicated

HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION (except for finger stick glucose monitoring per infusion policy if ordered by referring prescriber above). The prescribing physician is otherwise responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.

7. **Required Baseline Lab/Testing have been completed**:

[ ] Clinical Activity Score (CAS) _____ (please attach clinical documentation) [ ] CBC/CMP, date: _____

8. **Patient Assistance & REMS Program Enrollment**

[ ] Yes, patient has been enrolled in _____ program. (Provide Copy Enrollment Forms)
[ ] No, patient has not been enrolled in any programs.

7. **Physician's Name**: _____ **Phone:** _____
Physician's Signature: _____**Date:** _____

(This drug administration order form is valid for 12 months)