



**Birmingham, AL**  
F: 205-271-9971

**Huntsville, AL**  
F: 256-417-6408

**Knoxville, TN**  
F: 865-934-0249

**Nashville, TN**  
F: 615-645-4791

**Chantilly, VA**  
F: 703-935-2061

**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