ALL ORDERS MUST BE SIGNED AND DATED BY THE REFERRING PROVIDER

ALLERGIES/REACTIONS (REQUIRED):	Yakima Outpatient Infusion Care 808 N 39th Ave Yakima WA 98902 Phone: 509-575-1174 Fax: 509-577-5021
ORDERS WITH CHECK BOXES	When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.
CODE STATUS	Patients will be considered FULL CODE unless marked otherwise. If the patient has a POLST, advance directive, or living will, please include a copy with the orders.

TEPROTUMUMAB-TRBW (TEPEZZA)

Patient Name:____ Requested Start Date: _________/______/_______
Date of Birth:________/______/________ Patient Weight: ___________________ kg Patient Height: _______________

DIAGNOSIS & ICD-10 CODE:
❑ Thyroid Eye Disease (ICD-10: _________) ❑ Other: _____________________________ (ICD-10: _________)

REQUIRED: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with this order, scheduling of treatment will be delayed until complete information is available

ROUTINE LABS: ❑ Other: ____
ROUTINE LAB FREQUENCY: ❑ Each Infusion | ❑ Other: _____________

ACCESS: *Access and maintain IV site or Port-A-Cath in accordance with the appropriate MYM OIC P&Ps*

TREATMENT REGIMEN: *(another brand of drug, identical in form and content may be dispensed unless "DAW" or "BRAND ONLY" is written next to the drug name)*

Teprotumumab-trbw (Tepezza)

❑ Initial Infusion:
10 mg/kg x _________ kg = _________ mg/dose IV x1 infusion over 90 minutes
In 100 mL NS for doses < 1800 mg; in 250 mL NS for doses ≥ 1800 mg

❑ Subsequent/Maintenance Infusions:
20 mg/kg x _________ kg = _________ mg/dose IV every 21 days x7 additional doses
In 100 mL NS for doses < 1800 mg; in 250 mL NS for doses ≥ 1800 mg
Administer over 90 minutes for first 2 infusions, per manufacturer's instructions
Administer over 60 minutes for subsequent infusions if no reaction, per manufacturer's instructions

MONITORING: Vitals at baseline and at completion of infusion.
PATIENT EDUCATION: Signs and symptoms of hyperglycemia and medication-associated hyperglycemia management
SUPPORTIVE CARE: Administer hypersensitivity reaction/anaphylaxis management per MYMH OIC protocol as necessary.

DISCHARGE: 30 minutes after infusion is complete when vital signs are stable and hypersensitivity symptoms are absent. Waiting period can be waived by patient on subsequent infusions.

Provider Signature: ____ Date: _________________________
Print name: ____ Phone # __________________ Fax # _________________________

****Expires 12 months from written date****

Patient Identification - Attach Patient Label

Name:

MRN:

Age / Sex and Gender:

TEPROTUMUMAB-TRBW (TEPEZZA)

Yakima Memorial Hospital