



RHEUMATOLOGY & INFUSION THERAPY CLINIC
Green Bay • Fox Valley • Marinette • Oshkosh
Phone: 920-430-8113 • Infusion Fax: 920-965-6389
osmsgb.com

Tepezza (Teprotumumab-TRBW)

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: ☐ Green Bay ☐ Neenah ☐ Marinette

PATIENT INFORMATION	
Date:	Patient Name: DOB:
☐ NKDA Allergies:	Weight (kg):
Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date:	Next Due Date:
PROVIDER INFORMATION	
Office Contact Name:	Office Email:
Prescribing Providers Name:	Provider NPI:
Office Address:	City: State: Zip:
Office Phone Number:	Office Fax Number:
DIAGNOSIS AND ICD 10 CODE	REQUIRED DOCUMENTATION
☐ Thyroid Eye Disease ICD 10 Code: E05.00 ☐ Other: _____ ICD 10 Code: _____	☐ This signed order form by the provider ☐ Patient demographics AND insurance information (copy of cards) ☐ Clinical/Progress notes ☐ Lab and Tests supporting primary diagnosis
List Tried & Failed Therapies, including duration of treatment: 1. 2. 3.	
PREMEDICATION ORDERS	
☐ No premeds ☐ Acetaminophen (Tylenol) PO ☐ 500mg ☐ 1000mg ☐ Diphenhydramine (Benadryl) PO / IV ☐ 25mg ☐ 50mg (if route is not circled PO will be administered) ☐ Methylprednisolone (Solu-Medrol) IV ☐ 125mg ☐ 62.5mg ☐ Fexofenadine (Allegra) PO ☐ 180mg	
MEDICATION ORDERS (order will expire in 1 year unless otherwise specified)	
Initial IV dose: ☐ Tepezza 10 mg/kg IV once, initial dose Maintenance Dosing (will start 3 weeks after initial dose, when applicable): ☐ Tepezza 20mg/kg IV every 3 weeks x 7 doses Other (please include dose, route, frequency, and number of refills): ☐ Tepezza _____ PLEASE NOTE: First and second doses will be administered over 90 minutes, and if tolerated, subsequent doses will be administered over 60 minutes.	
<i>*Please note: If an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion, or discontinuing the medication.</i>	
LAB ORDERS	
☐ CBC w/ diff ☐ CMP ☐ CRP ☐ ESR ☐ Vitamin D OH Total ☐ Hep B Surface Antigen ☐ Quantiferon TB Gold ☐ Other: ☐ w/ every infusion ☐ w/ every other infusion ☐ Other:	

Provider Name (Print)

Provider Signature:

Date:

Fax Referral to 920-965-6389

All information contained in this order form is strictly confidential and will become a part of the patient's medical record.