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Tepezza® (teprotumumab) Order Form
Epic Referral: REF115223

Patient Name: _____ **DOB:** _____

Address: _____

Phone: _____ **ICD-10 Diagnosis:** _____

Patient weight: _____ (include units lbs/kg) **Date that weight was taken:** _____

**** Dose will be rounded down to the nearest vial size if the difference is < 5% of the total dose to reduce medical waste. ****

Dose 1:

- IV teprotumumab (Tepezza) 10 mg/kg infused over 90 minutes x 1 dose followed by the dosing below 3 weeks later
 - Will be diluted in appropriate amount of 0.9% NaCl per package insert

Doses 2-8:

- IV teprotumumab (Tepezza) 20 mg/kg infused over 90 minutes every 3 weeks x 7 doses
 - Will be diluted in appropriate amount of 0.9% NaCl per package insert
 - If tolerated over 90 minutes for dose 2, can give subsequent doses over 60 minutes
 - 8 total doses of tepezza will be given including the 10 mg/kg dose

Other Orders/Comments: _____

Port/PICC care per protocol will be performed if applicable including heparin flush (500 units/5mL) and cathflo (2 mg) PRN for patients with a port

Prescriber Printed Name: _____

Prescriber Full Address: _____

Office Phone Number: _____ **Office Fax Number:** _____

Prescriber Signature: _____ **Date:** _____