Infusion ASSOCIATES

Phone: 616-954-0600 Fax: 616-954-1675

Tepezza IV Infusion

(teprotumumab-trbw)

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications and **Recent Visit Notes***

Referral status: □ NEW referral □ Dose or frequency change □ Order renewal

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

ICD-10 : _____, _____, _____

Advised patients to use an adequate form of contraception during and for 6 months post treatment? □ Yes □ N/A
Diabetic patients advised of potential for hyperglycemia? □ Yes □ N/A non-diabetic
Patients with IBD advised of potential flare of disease? □ Yes □ N/A
Has the patient tried and failed steroids? □ Yes □ No
What is the clinical activity score (CAS) in the most severely affected eye? _____ Date: _____
Has the physician discussed with the patient to stop smoking if patient is a current smoker? □ Yes □ No

Pre- Medications:

Diphenhydramine PO	25mg or 50mg	□Yes □ No
Cetirizine PO	10mg	□Yes □ No
Acetaminophen PO	650mg	□Yes □ No
Methylprednisolone IVpush	_____mg	□Yes □ No

Start Date of Infusion: _____/_____/_____

Tepezza (teprotumumab-trbw) IV Dosage:

□ Dose 1 - 10 mg/kg

□ Dose 2-8 - 20 mg/kg

Frequency: EVERY 3 weeks for 8 total treatments

Printed Provider's Name: _____

Provider Signature: _____

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