

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ lbs kg

Allergies: _____ NKDA

Patient status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm (hyperthyroidism) E05.00 Other _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

PRE-MEDICATION

Acetaminophen (Tylenol) PO 500 mg 650 mg 1000 mg
 Diphenhydramine (Benadryl) PO IV 25 mg 50 mg
 Methylprednisolone (Solu-Medrol) IV 40 mg 125 mg
 Cetrizine (Zyrtec) 10 mg PO
 Other: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
<input checked="" type="checkbox"/> TEPEZZA (Teprotumumab-trbw), IV in 0.9% sodium chloride, intravenous infusion	<input type="checkbox"/> 10mg/kg <input type="checkbox"/> 20mg/kg	<input type="checkbox"/> Order is valid for 8 total infusions unless otherwise indicated <input type="checkbox"/> Every 3 weeks

Infuse over 90 minutes for the first two infusions. If well tolerated, then minimum time for subsequent infusions can be reduced to 60 minutes.

Flush with 0.9% sodium chloride at infusion completion.

Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

Order is valid for 8 total infusions unless otherwise indicated. Order valid for 1 year unless otherwise stated.

LABORATORY ORDERS

<input type="checkbox"/> CBC	<input type="checkbox"/> at each dose	<input type="checkbox"/> every _____
<input type="checkbox"/> CMP	<input type="checkbox"/> at each dose	<input type="checkbox"/> every _____
<input type="checkbox"/> Finger Stick Blood Glucose	<input type="checkbox"/> at each dose	<input type="checkbox"/> every _____ infusion(s)
<input type="checkbox"/> Other _____	<input type="checkbox"/> at each dose	<input type="checkbox"/> every _____

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

Patient Demographics Insurance card Progress Notes supporting DX Free T3 and Free T4
 Clinical Activity Score (CAS) Thyroid Panel with TSH HbA1C (if available)

Provider Signature _____

Date _____