Patient Name: _____ DOB: ___/___/_____ Date of Last Infusion: ___/___/_____
Height_____ Weight_____

Infusion Location: (state and Site) _____

TEPEZZA® (teprotumumab-trbw) Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):	
_____ Thyroid Eye Diseases (ICD-10)	_____ Other: _____ (ICD-10)

- Hold infusion and notify provider for
  - Abnormal vital signs or chance of pregnancy
  - Worsening IBD
  - Signs/symptoms of hyperglycemia (increased thirst, headaches, blurred vision, frequent urination, weight loss, dry mouth, confusion, SOB, sweet-smelling breath)

    No POC glucose testing will be performed in infusion clinic

    No POC pregnancy testing will be performed in infusion clinic
- Monitor for hearing loss, assess hearing impairment
- If infusion-related reaction occurs, stop infusion follow Hypersensitivity Reaction Management Protocol as clinically indicated.

Dosing, Mixing and Administration:

❑ First Dose: Administer TEPEZZA 10 mg/kg x (current weight) _____ kg = _____ mg x 1 dose ❑ Subsequent Doses (2-8): TEPEZZA 20mg/kg x (current weight) _____kg = _____ mg x 7 doses
❑ Doses up to 1800mg mix in NS to final volume of 100ml ❑ Doses greater than 1800mg, mix in NS 250ml
Infuse over 90 mins for the first 2 doses. If patient tolerates well, all future infusions can infuse over 60mins Record vitals before, during and after each infusion. (every 30mins)

Frequency (chose one):

- ❑ Every 3 weeks (8 infusions total)
- ❑ Every _____ weeks

Additional Orders:

Provider name (print)_____ Date:_____

Provider signature: _____ Time: _____