# TEPEZZA INFUSION ORDER
# (Teprotumumab-trbw)

INFUSIONMED | USA
LIVING YOUR BEST LIFE. ONE DROP AT A TIME.

Date: ____/____/_____

## PATIENT INFORMATION

Patient Name:_____ DOB:___/____/____ Phone: _____

Height: _____ Weight _____ lbs / kg

Allergies: _____

Diagnosis: _____ ICD-10: _____

TB Test Date: _____/____/____ Result: _____

Labs to be drawn by: O Infusion Clinic O Referring Physician

Lab Orders: _____

## PRE-MEDICATIONS

| | | | | | |
|---|---|---|---|---|---|
| Diphenhydramine | O PO | O IV | O 25mg | O 50mg | O PRN |
| Acetaminophen | O PO | | | O 650mg | O PRN |

## TEPEZZA (TEPROTUMUMAB-TRBW)

Dose: Infusion 1: _____mg (10mg /kg) Infusion 2-8: _____mg (20 mg/kg)
Frequency: Q3 weeks, 8 infusions total
Start Date of Infusion: ___/___/___

## PROVIDER INFORMATION

Provider's Name: _____ Signature: _____

Phone: _____ Fax: _____ Date: _____/_____/_____

Office Address: _____

Email Address: _____ Contact Person: _____

## PLEASE SEND COPY (FRONT AND BACK) OF INSURANCE CARD

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