vitalcare of LITTLE ROCK
Fountains Infusion Center
15200 Chenal Pkwy. Suite 300 Little Rock AR
Phone: 501-451-6080 Fax:501-451-6081

Tepezza (teprotumumab-trbw) Order

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes, CAS Score (required), TSH, T3, and T4 labs**

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Pt. Weight _____ kg

Diagnosis:

☐ Thyroid Eye Disease ICD-1) Code:_____

TEPEZZA ORDERS

First Infusion:

☐ Tepezza 10mg/kg IV over 90 minutes

Subsequent Infusions:

☐ Tepezza 20mg/kg IV every 3 weeks after week 0 for 7 doses

Second infusion infuse over 90 minutes, then if tolerated, remaining doses infuse over 60 minutes

Pre-Medication Orders: Tylenol 650mg PO, please choose one antihistamine:

☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Loratadine 10mg PO

Does the Patient have a history of Diabetes? ☐ Yes ☐ No

**Patients with pre-existing diabetes should be under appropriate glycemic control before receiving Tepezza.*

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

Lab orders: _____ Frequency: _____

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	