ARJ Infusion SERVICES

Specialty Pharmacy and Nursing

FAX completed form to ARJ 877-451-8955

Intake Specialist 866-451-8804
referral@arjinfusion.com
arjinfusion.com/referrals

Tepezza (teprotumumab-trbw) I Order Form

Patient Name: ____ DOB: _________________ Phone: _________________________

Address: _____________________________________ City: ____________________________ State: _______ Zip: ___________

1. For new patients, please submit with form:

☒ Copy of insurance card ☒ Patient demographics ☒ History & physical ☒ Pertinent labs and test results

2. Patient Information

☐ Male ☐Female Height: _____________ in/cm Weight: _____________ lbs/kg Allergies: _______________________

Is this the first dose? ☐Yes ☐No, date of last infusion: ________________ Line type: ☐ PIV ☐PICC ☐Port ☐Other

3. Diagnosis and Clinical Information

Diagnosis: ☐ Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm (hyperthyroidism) ICD-10: E05.00

☐ Other: ____ ICD-10: ___________

4. Prescription Information

Medication	Tepezza 500mg vial
Dosing / Frequency	☐ Initial dose: 10 mg/kg (_________ mg) IV x 1 dose ☐ Maintenance: 20 mg/kg (_________ mg) IV every 3 weeks x 7 doses, beginning 3 weeks after initial dose
Administration	☒ Reconstitute vial(s) per manufacturer guidelines and dilute dose with 0.9% Sodium Chloride. For doses <1800 mg use a 100 mL bag. For doses ≥1800 mg use a 250 mL bag (remove equal volume first) ☒ Infuse first 2 infusions over 90 min, may infuse subsequent infusions over 60 min if well tolerated
Quantity / Refills	Dispense 3 week supply of all selected medications Refill x 7 (or quantity sufficient to complete a total of 8 Tepezza infusions) Other: ____

5. Additional Orders

☒ RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per ARJ Policy and Procedure

☒ RN to monitor patient for minimum of 30 min post infusion. RN to educate patient on possible side effects, allergic reactions, and when to contact physician

☐ Other: ____

6. Adverse Reaction Orders

In the event an infusion reaction occurs:

☒ Interrupt or slow the rate of infusion and use appropriate medical management

☒ Notify prescriber. Consideration should be given to pre-medicating and/or infusing subsequent infusions at a slower rate

7. Prescriber Information

Prescriber Name: ____ Office Contact: ____

Address: ____ City: ____________________ State: ________ Zip: ___________

Phone: ____________________________ Fax: _____________________________

License No.: ____________________________ DEA NO.: _____________________________ NPI: _____________________________

______________________________________ ____________ ______________________________________ _____________

Physician Signature (Substitution Permitted) Date **Physician Signature (Dispense as Written)** Date

By signing I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment. ARJ Infusion Services has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.

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