Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: _____ Patient D.O.B._____

Current Height: _____ Current Weight_____

Patient Phone # (_____) _____-_____ Gender_____

Patient Address _____

City_____ State _____ Zip Code_____

Related Diagnosis Code (ICD-10 code): _____

Referring Provider (Please Print) _____

Office Phone # (_____) _____-_____ Office Contact: _____

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

Tepezza ® (Teprotumumab) Treatment Plan

Patient Name: _____ **Patient DOB** _____

General

☐ Diagnosis- Thyrotoxicosis with diffuse goiter w/o thyrotoxic crisis or storm or documented thyroid eye disease

ICD-10 Code _____

Pt. Weight _____ Pt Height _____ Known Allergies _____

Requested Start Date ____/____/_____

Has patient previously received this medication:

☐ No ☐ Yes, if so, date of last infusion ____/____/_____ and number of previous infusions _____

Infusion (Month 1 to 12) Duration: 12 Months

☑ Vital Signs (Month 1 to 12)
every 30 min, Resp, BP, HR, Temperature on admission to the unit and prior to infusion HR, BP and prior to discharge

☑ Pharmacy to dose based on actual body weight. Doses may be rounded to the nearest vials size or nearest 50mg as long as dose adjustments to not exceed 10% of prescribed dose.

Pre- Treatment Medications

Tylenol (Month 1 to 12)

☐ *650 mg, Oral, Tab, Day of Tx*
Comments: Administer 30 minutes before dose

Benadryl (Month 1 to 12)

☐ *25 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before dose

☐ *50 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before dose

SOLU-Medrol (Month 1 to 12)

☐ *40 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before dose

☐ *125 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before dose

Loading Dose Tepezza (teprotumumab)

☐ *10 mg/kg, IV Piggyback, Powder-Inj, Day of Tx* ***[Less Than 180 kg]***
Comments: for doses <1.8 g mix in NS 100 mL. Infuse over 90 minutes for the first 2 infusions

☐ *10 mg/kg, IV Piggyback, Powder-Inj, Day of Tx* ***[Greater Than or Equal To 180 kg]***
Comments: for doses >1.8 g mix in NS 250 mL. Infuse over 90 minutes for the first 2 infusions

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____

Tepezza ® (Teprotumumab) Treatment Plan

Maintenance Dose Tepezza (teprotumumab)- to be administered every 3 weeks beginning after initial infusion for a total of 8 doses including loading dose.

☐ *20 mg/kg, IV Piggyback, Powder-Inj, Day of Tx **[Greater Than or Equal To 90 kg]***
Comments: for doses >1.8 g mix in NS 250 mL. Infuse over 90 minutes for the first 2 infusions; may reduce infusion time to 60 minutes for subsequent infusions if well tolerated

☐ *20 mg/kg, IV Piggyback, Powder-Inj, Day of Tx **[Less Than 90 kg]***
Comments: for doses <1.8 g mix in NS 100 mL. Infuse over 90 minutes for the first 2 infusions; may reduce infusion time to 60 minutes for subsequent infusions if well tolerated

☑ Communication Order (Month 1 to 12)
Ensure negative HCQ urine screening completed prior to each infusion for females 11-55 years of age with no history of hysterectomy or bilaterial oophorectomy

☑ Communication Order (Month 1 to 12)
Patient must stay in infusion area for 30 min post infusion. If vital signs normal may be discharged to home. If abnormal, call physician.

☑ Notify Provider (Month 1 to 12)
for fever/chills, chest pain, hypotension, hypertension, dyspnea, Pruritis, urticaria, persistent flushing Temperature > 100 or HR <50 or > 130

☑ Notify Provider (Month 1 to 12)
for positive HCG urine screen prior to infusion initiation.

☑ INF Infusion Room Orders Subphase (Month 1 to 12)

Labs (Month 1 to 12) Duration: 12 Months

☑ HCG Pregnancy Screening- Urine (If Needed)
☑ CBC w/ Diff (If Needed)
☑ BMP (If Needed)
☑ Urinalysis with Microscopic, if indicated (If Needed)

Patient Monitoring Acknowledgement:

***** CMC Outpatient Infusion Services (OIS) shall ensure negative HCG urine pregnancy screen is completed for females age 11-55 years of age with no history of hysterectomy or bilateral oophorectomy. Referring provider acknowledges that patients who fall into this category for screening have been educated about the reproductive risks associated with teprotumumab infusion, the need for screening prior to each infusion, and have received counseling related to the need for effective contraception during treatment and for a minimum of 6 months following therapy completion.

Provider Initials_____

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____