Phone: (305) 306-7147 | Fax: (305) 402-9559 | Email: contact@clearwellinfusion.com

Clearwell
Infusion Centers

TEPEZZA (teprotumumab-trbw)

PATIENT DEMOGRAPHICS

Patient Name: _____
Date of Birth: _____ M: ☐ F: ☐ Address: _____
Phone: _____ City, State, Zip: _____
Email: _____

Allergies:

PRIMARY DIAGNOSIS

ICD-10 Code:

DOCUMENTATION (PLEASE ATTACH)

Clinical / Progress Notes, Labs, Tests supporting primary diagnosis

☐ Pregnancy test (if applicable). Tepezza may cause fetal harm when administered to a pregnant woman. Please counsel patients on appropriate forms of contraception
☐ Tepezza may cause hearing loss. Referring provider to assess hearing prior to initiation and monitor during, and after treatments
☐ Referring provider to monitor the patient for hyperglycemia and treat/refer appropriately
☐ Finger Stick Blood Glucose
  ☐ At each dose ☐ Every _____ infusions
  Hold/call parameters:*_____
  *If not included, blood glucose will be assessed per Clearwell infusion centers policy

Clearwell Infusion Centers will draw maintenance labs unless otherwise directed by Referring Provider

PRE-MEDICATION

☐ Acetaminophen 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Ceterizine 10mg PO
☐ Loratadine 10mg PO
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ Other:

PRIMARY MEDICATION ORDER

Dosage

☐ 10mg/kg for the first infusion
☐ 20mg/kg for infusions 2-8

Patient Weight:

_____ lbs
_____ kg

Frequency

☐ Every 3 weeks, 8 total infusions

NOTES

ORDERING PROVIDER

Provider Name: _____ NPI: _____
Practice Name: _____ Phone: _____
Office Contact: _____ Fax: _____
Practice Address: _____
City, State, Zip: _____

Provider Signature: _____ Date: _____