Atrium Health Wake Forest Baptist

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Wake Forest Baptist Infusion - Westchester **Fax 336-802-2389**

Tepezza® (teprotumumab-trbw) Infusion Order (Revised 08.25.2026)

All orders with a √ will be placed.

Patient Demographics:

Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:

Allergies: (please list all allergies or attach list)

☐ NKDA

Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)

☐ E05.00 - Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm

☐ H05.831 - Thyroid orbitopathy, right orbit	☐ H05.832 - Thyroid orbitopathy, left orbit
☐ H05.833 - Thyroid orbitopathy, bilateral	☐ Thyroid orbitopathy, unspecified orbit
☐ Other:	

Required Documentation: (*required prior to scheduling*)

Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion:
Complete Medication List - Include all tried and failed meds	Next infusion due date:
	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
Diagnostic Studies Pertinent to Medication Ordered	☐ Yes ☐ No

Treatment Parameters

☑ Hold treatment and notify provider IF:
- Temperature is GREATER THAN 100oF;
- Patient complains of symptoms of acute viral or bacterial infection;
- Patient is taking an antibiotic for current infection.

Nursing Communication:

☑ Start PIV/Access CVC and flush device per approved Atrium Health protocol.

☑ Obtain vital signs PRE-treatment and POST-treatment. Obtain vital signs PRN during treatment.

☑ Monitor patient for signs of reaction for 30mins AFTER completion of 1st infusion and subsequent infusions PRN IF previous signs of reaction observed.

Pre-Medications:

☐ Acetaminophen (Tylenol) 650mg PO ONCE

☐ Diphenhydramine (Benadryl) 25mg PO ONCE

☐ Diphenhydramine (Benadryl) 25mg IV ONCE

☐ Loratadine (Claritin) 10mg PO ONCE

☐ Methylprednisolone Sodium Succinate (Solu-Medrol) 125mg IV ONCE

Infusion Therapy:

☐ Teprotumumab-trbw (Tepezza) 10mg/kg IV over 90 minutes ONCE- Week 0

☐ Teprotumumab-trbw (Tepezza) 20mg/kg IV over 90 minutes ONCE- Week 3

☐ Teprotumumab-trbw (Tepezza) 20mg/kg IV over 60 minutes ONCE- Week 6

☐ Teprotumumab-trbw (Tepezza) 20mg/kg IV over 60 minutes every 3 weeks x 5 doses

Supportive Care Medications:

☑ Acetaminophen (Tylenol) 650mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give first if not given as a pre-medication.

☑ Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give second after acetaminophen.

☑ Ondansetron (Zofran) 4mg IV ONCE PRN nausea/vomiting.

Hypersensitivity Protocol:

☑ Initiate Atrium Health Wake Forest Baptist approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Wake Forest Baptist Infusion - Westchester website at www.wakehealth.edu/locations/clinics/i/infusion-westchester

Prescriber Information:

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

Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted

Signature:	Date: