

 <p>ADULT AMBULATORY INFUSION ORDER 5/2026 Teprotumumab-trbw (TEPEZZA) Infusion</p>	<p>NAME: BIRTHDATE: INSURANCE: PROVIDER NAME: CLINIC NAME and Phone number:</p> <p style="text-align: center;">Patient identification</p>
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Weight: _____ kg Height: _____ cm Allergies: _____ Diagnosis Code: _____

Height & weight are required for a complete order. Treatment Start Date: _____

****If treatment not started within 90 days, new orders with updated date/signature will be required. Otherwise, orders are valid for 1 year from signature date.****

- 1) Patient name and date of birth must be on EACH page of this order form. This form will be returned if any left blank.
- 2) Send FACE SHEET and complete copy of INSURANCE information. Send H&P or most recent chart note, must be **within the past 12 months.**
- 3) Send a copy of related lab results if not available for review in Epic.

REQUIRED labs: Results within 90 days must be available prior to initiation of therapy. If not included, or outside of this timeframe, we will coordinate labs to be redrawn. If this is continuation of therapy any missing pre-screening labs will be drawn during infusion appointment, but we will not wait for results prior to proceeding.

- ✓ Basic Metabolic Panel, STAT, baseline prior to first dose & every 12 weeks.
- ✓ Hgb A1C, STAT, baseline prior to first dose & every 12 weeks.

For FEMALE patients: Pregnancy testing is required prior to receiving each infusion, unless patient meets exclusion criteria below. Review exclusion list below & select any that apply:

Exclusion Criteria:


- Postmenopausal: >55 years old and no menstrual periods for greater than or equal to 12 consecutive months.
- Hysterectomy or Bilateral Salpingo-oophorectomy: Surgical removal of uterus and both ovaries and fallopian tubes.
- Ovarian Failure: Laboratory confirmation (FSH & Estradiol) in menopausal range and/or history of whole pelvic radiation therapy.
- Tubal Ligation or Other Surgical Sterilization: Documented procedure leading to sterilization.
- ✓ If none of the exclusion criteria apply, we will proceed with pregnancy screening & testing per Providence policy; with one of the orders will be placed per local protocol.
- ✓ Serum, HCG Qualitative, Stat, PRN, STAT. Results valid for 7 days.
- ✓ Pregnancy, Urine, Qualitative, PRN, STAT. Results valid for 7 days.

Optional LABS to be done at infusion appointments (in addition to standard ones listed above):

- Lab: _____, Routine, every _____.
- Lab: _____, Routine, every _____.

Optional PRE-MEDICATIONS: (Select all that apply, to administer 30 minutes prior to infusion.)

- Acetaminophen (TYLENOL) tablet, 650 mg, oral, every visit.
- Diphenhydramine (BENADRYL) tablet, 25 mg, oral, every visit.
- Hydrocortisone (PF) (SOLU-CORTEF) 200 mg, injection, IV push. Mix with 2 mL sterile water.

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MEDICATION & FREQUENCY:

- ✓ Teprotumumab-trbw (TEPEZZA) in sodium chloride 0.9% infusion (dilution per pharmacy protocol), IV.

Induction AND Maintenance doses:

- ✓ Induction: Give 10 mg/kg, IV, infuse over 90 minutes, ONCE.
21 days later give 20 mg/kg, infuse over 90 minutes, ONCE.
- ✓ Maintenance: Give 20 mg/kg, IV, infuse over 60 minutes, every 21 days, for 6 doses total.
If infusion not well tolerated, infuse over 90 minutes for subsequent infusions.

OR

- Maintenance doses ONLY:** *To continue treatment with maintenance orders. If infusions were received elsewhere, date(s) of last infusion(s) & location: _____.*

Give 20 mg/kg, infuse over 60 minutes, every 21 days for _____ doses total.
If infusion not well tolerated, infuse over 90 minutes for subsequent infusions.
Maximum 8 doses allowed per round of treatment between infusion sites.

Standard included Nursing Orders:

- ✓ Vital signs per clinic routine.
- ✓ Insert peripheral IV if no iv access. Sodium chloride 0.9% (NS) 10 ml flush.
- ✓ May use/access CVC line and give 500 units (5ml) heparin injection for central line care.
- ✓ Sodium chloride 0.9% (NS) bolus 250 ml, Flush before and after IV medication(s) and as needed with NS.

HYPERSENSITIVITY INFUSION REACTION ORDERS

STOP infusion if:

MILD REACTION: Localized pruritus, rhinitis, localized rash, fever greater than 38 degrees C.

1. Stop infusion and maintain IV access with NS line.
2. Notify MD of symptoms and infusion reaction orders initiated.

MODERATE REACTION: Generalized pruritus, generalized flushing, rash, back pain, mild dyspnea, chills, hypotension with SBP less than 90 mmHg or greater than 20% decrease in SBP.

1. Stop infusion, but do not discard infusion bag/bottle unless instructed by MD that therapy is to be discontinued.
2. Maintain IV access with NS line.
3. Place patients in a supine position with lower extremities elevated unless respiratory distress or nausea/vomiting.
4. Maintain airway.

SEVERE REACTION: Respiratory distress (bronchospasm, stridor, wheezing, persistent cough, respiratory depression, cardiac arrhythmia, chest pain, generalized urticaria (hives), syncope, gastrointestinal symptoms (abdominal pain, N/V, diarrhea), hypotension SBP less than 80 mmHg, face/throat/tongue swelling, shock, loss of consciousness.

1. Stop infusion, but do not discard bag/bottle unless instructed by MD that therapy is to be discontinued.
2. Stay with patient and have another nurse notify MD of symptoms and infusion reaction orders initiated.
3. Place patients in supine position with lower extremities elevated unless respiratory distress or nausea/vomiting.
4. Maintain airway.
5. Maintain IV access with NS line.
6. Inpatients: Activate code blue for loss of blood pressure, pulse, or consciousness.

MEDICATIONS:

- Acetaminophen (TYLENOL) tablet 650 mg, Oral, EVERY 4 HOURS PRN, Pain, Other, Mild reaction.
- DiphenhydrAMINE (Benadryl) injection, 25 mg, Intravenous, EVERY 15 MIN PRN, Moderate or severe reaction, may repeat x1. For 2 doses.
- Methylprednisolone sodium succinate (solu-MEDROL) 62.5mg/ml injection, 125 mg, Intravenous, ONCE PRN, Severe reaction. For 1 dose. Mix with 2 mL provided diluent to make 62.5 mg/mL.
- Famotidine (PEPCID) injection 20 mg, Intravenous, ONCE PRN, Moderate reaction, or anaphylaxis. Dilute 2 mL of famotidine with 8 mL of normal saline to a final concentration of 2 mg/mL. Administer ordered dose over a period of at least 2 minutes.
- Albuterol 90 mcg/puff inhaler 2 puff, Inhalation, ONCE PRN, Severe reaction. For 1 dose. Shake well. Use with spacer.
- Start oxygen. For MODERATE Reaction: Start 2 liters O2 per nasal cannula as needed for SpO2 less than 93%. For SEVERE Reaction: Start continuous pulse oximetry. Administer 6 to 8 liters per minute (LPM) via face mask, or up to 100% oxygen to maintain oxygen saturation greater than 90%.

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- EPINEPHrine 1 mg/mL injection 0.3 mg. Intramuscular, EVERY 5 MIN PRN, Anaphylaxis. For 3 doses. Administer in the anterior lateral thigh using 1 - 1.5-inch needle for airway obstruction symptoms and/or hypotension.
- Sodium chloride 0.9% (NS) infusion 500ml. At 500 mL/hr., Intravenous, PRN, Moderate reaction, or anaphylaxis. Run wide open to gravity.

Physician communication: Monitor all patients for increased blood glucose or hyperglycemia. Patients with pre-existing diabetes should be under appropriate glycemic control before receiving Tepezza.

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*).
I hold an active, unrestricted license to practice medicine in Oregon.

My physician license Number is # _____ **and I am acting within my scope of practice and authorized by law to order infusion of the medications and blood products described above for the patient identified on this form.**

Provider’s printed name: _____
Provider’s signature: _____
Date: _____

Please complete the following intake questions.

Mobility status

- Independent (no mobility devices used)
- Uses assistive device (walker, cane)
- Uses a wheelchair, but can transfer with minimal or no assistance
- Moderate to maximum assistance with mobility, explain: _____
*Clinic location will reach out if unable to accommodate mobility assistance needs.

Bariatric needs

- Yes, briefly describe _____
- No

Transportation concerns

- Yes, briefly describe _____
- No

Interpreter Service required

- Yes, language _____
- No

Outpatient Infusion Services Intake Team:

Please check the appropriate box for the patient’s preferred infusion center location:

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> PORTLAND | Phone-503-215-6046 Fax-503-487-3582 |
| <input type="checkbox"/> WILLAMETTE FALLS | Phone-503-215-6046 Fax-503-487-3582 |
| <input type="checkbox"/> MEDFORD | Phone-541-732-7000 Fax-541-732-3939 |
| <input type="checkbox"/> HOOD RIVER | Phone-541-387-6445 Call for fax # |
| <input type="checkbox"/> SEASIDE | Phone-503-717-7650 Fax-503-470-3146 |
| <input type="checkbox"/> NEWBERG | Phone-503-537-6040 Fax-503-205-8720 |