TEPEZZA Referral Form

Date:_____

Evolutionary Pharmacy Solutions

Fax Referral To: 1-800-239-0363

Phone: 1-844-800-5377

EPSRX

PATIENT INFORMATION:

Last Name:	First Name:	Home Phone:	Mobile:		
Home Address:		City:	State:	Zip:	
Delivery Address:		City:	State:	Zip:	
Date of Birth:	Gender:	Language:	Email:		
Caregiver Name:		Relationship:	Number:		

HEATLHCARE PROVIDER INFORMATION

Practice Name:	Dr Name:	Phone:	Fax	
Address:	City:	State:	Zip:	
NPI:	DEA:	License:	UPIN:	

INSURANCE INFORMATION *Provide Copy of Front & Back of Insurance Card *

Medical Insurance Name:	Prescription Insurance Name:

CLINICAL INFORMATION * Provide Medical Records *

TED: ☐ Yes ☐ No **Diagnosis:** ☐ E05.00 ☐ E06.3 ☐ Other (specify):_____ | Pregnancy Test: ☐ Negative ☐ Using Contraceptive Method

Other Comorbidities:_____ | Weight:

Therapy: ☐ New to Therapy ☐ Continuing Therapy ☐ Next Due Date (if applicable):_____ | ☐ CAS Score (0-10) _____

Laboratory Orders: ☐ CBC ☐ At Each Dose ☐ Every_____ ☐ CMP ☐ At Each Dose ☐ Every_____ ☐ Other: _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Tepezza (teprotumumab-trbw)	☐ 500mg single dose vial	☐ Week 0: 10 mg/kg IV for 1st infusion. Dose: _____	☐ 21 day supply	
		☐ Week 3: 20 mg/kg IV every 3 weeks for 7 infusions Dose: _____		

Reconstitute Tepezza vial with 10ml Sterile Water & gently swirl**. Dilute** with 0.9% Sod Chl. For doses < 1800mg use a 100ml bag & doses ≥ 1800mg use a 250mg bag. Discard 10.5ml of 0.9% Sodium Chloride from bag prior to adding diluted Tepezza into bag.

Administer the first 2 infusions over 90 minutes. Subsequent infusions may be reduced to 60 minutes if well tolerated. If infusion reaction occurs, interrupt or slow the rate of infusion.

Pre – Medication ** Not required but if patient experiences infusion reaction, consider premedicating 30 minutes prior infusion **

Medication	Dose	Directions	Refills	QTY
☐ Acetaminophen (Tylenol)	☐ 500mg ☐ 1000mg PO			
☐ Diphenhydramine (Benadryl)	☐ 25mg ☐ 50mgg ☐ PO ☐ IV			
☐ Methylprednisolone (Solu-Medrol)	☐ 40mg ☐ 125mg IV			
☐ 0.9% Sodium Chloride	☐ 5ml syringe ☐ 10 ml syringe	Flush per protocol following infusion		
☐ Epinephrine Injection (Autoinjector)	☐ 0.3mg (Adult)			
☐ Anaphylaxis Medication Kit				
☐ Other:				

Nursing Coordination:

☐ **YES:** Provide home health nursing for ☐ education/training ☐ to administer ☐ reaction management ☐ 30 minute post-procedure observation.

☐ **NO:** Nursing not necessary:☐ Patient and/or caregiver are proficient with infusion ☐ Physician to administer in the office

☐ Nursing already established, if so provide agency contact information: _____

PRESCRIBER SIGNATURE: _____ **DATE:**_____

Verbal Readback ☐ Yes ☐ No ***Stamp signature not allowed, physician signature required ***

ADULT REACTION MANAGEMENT PROTOCOL

Observe for **hypersensitivity reaction**: Fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation, nausea, vomiting If reaction occurs:

- Stop infusion
- Maintain/establish vascular access
- Notify referring provider as clinically appropriate and follow clinical escalation protocol.
- EPSrx have the following PRN medications available for the following reactions.
  - Headache, pain, fever >100.4F, - Acetaminophen 500mg 1-2 tablets PO
  - Mild Hives, itching, redness, or rash - Diphenhydramine 25-50mg PO since dose, may repeat if needed
  - Severe hives, itching, redness, or rash- Diphenhydramine 25-50mg SIVP single dose, may repeat if needed
  - Nausea, vomiting, heartburn, acid reflux- Ondansetron 4mg ODT (may repeat x 1 in 20 minutes if nausea continues, max dose 8mg) or Famotidine 20mg PO
  - Hypotension (90/60), vasovagal response- Place patient in reclined position, administer 0.9% Sodium Chloride IV 250ml. May repeat to keep BP >90/60, maximum of 1000ml, monitor vital signs.
  - Chest pain/discomfort, shortness of breath- Call 911
  - Other _____
- When symptoms resolve resume infusion at 50% previous rate and increa se per manufactures guidelines

Severe allergic/anaphylactic reaction:

- If symptoms are rapidly progressing or continuing after administration of prn medications above and signs symptoms of severe allergic/anaphylactic reaction (angioedema, swelling of the mouth, tongue, lips, or airway, dyspnea, bronchospasm with or without hypotension or hypertension.)
  - Call 911
  - Initiate basic life support as needed
  - **Epinephrine**- administer 0.3mg of a 1:1,000 (1mg/ml) concentration intramuscularly (preferably outer thigh), may be repeated every 5-15 minutes as needed to a maximum of 2 doses.
  - Place patient in recumbent position, elevate lower extremities
  - Administer **diphenhydramine** 50mg IV or Famotidine 20mg IVP, if not previously given
  - Administer **methylprednisolone** 125mg IVP, if not previously given.
  - Continuous monitoring of blood pressure, pulse oximetry, and heart rate.
  - Notify clinical executive, DON or CMO, when appropriate. Must be done same day. Do not delay treatment.

Patient Name	**Patient Date of Birth**
Provider Name (Print)	
Provider Signature	**Date**