Comanche County Memorial Hospital

**Outpatient Infusion Center
Tepezza Order**

Please fax form to: 580-585-5472

Patient Information

Patient Name: DOB: Phone: Gender: M   F

Patient Address: Email: Insurance:

Additional Information Needed

Fax front/back of insurance card   Fax clinical/progress notes   Fax labs

Fax patient demographics   Fax current medication list   Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

E05.00 Thyotoxicosis with diffuse goiter without Thyrotoxic Crisis or Storm (Hyperthyroidism)

Other: DX: _____

Clinical Information:

New Therapy Induction   Therapy Change   Therapy Continuation

Patient Weight: _____ lbs/ _____ kg   Patient Height: _____ in/ _____ cm

Allergies: _____

Therapies Tried and Failed: _____

TB Test: Date: _____ Results: _____   Hep B Test: Date: _____ Results: _____

Does the patient have documented Thyroid Eye Disease (TED)? Yes or No   (If "No" patient is not a candidate for Tepezza)

Does the patient have venous access? Yes or No   If yes, What type? _____

If No, initiate IV access.

Lab Orders   Lab Orders to be done by

CBC w/o diff   CMP   HBsAg   HBsAB   HBcAB   Quantiferon Gold   T3   T4   TSH   Infusion Services

Other: _____   Referring Provider

Prescription Information

| Tepezza | Initial Dose: 10mg/kg beginning week |
| | Maintence Dose: 20mg/kg every 3 weeks after initial week for 7 additional infusions |

Misc Orders

_____	PICC/Midline/CAD dressing to be changed every 7 days
_____	**Flushes**
	10mL NS Flush Syringe PRN
	Heparin 500units/5mL Flush Syringe PRN
	50ml NS Bag PRN
	250ml NS Bag PRN

Standing Orders for Adverse Reaction

Stop infusion and initiate NS bolus   Epi 1:1000 1mL IM, IV or SQ for anaphylaxis

Notify Supervising physician and ordering provider   Oxygen 2-5L nasal cannula

Solu-Cortef 100mg SIVP signs of adverse reaction   Albuterol 2.5mg inhaled PRN to chest tightness

Benadryl 25 mg SIVP for hives or bronchial inflammation   Other: _____

Prescriber Information

Physician Name: _____   Official Contact Name: _____

Contact #: _____   Fax Number: _____

Address: _____   City/State/Zip: _____

NPI#: _____ DEA#: _____   State License #: _____

Physician's Signature   Date   Time