Ascension Rx

# Teprotumumab-trbw (Tepezza & Biosimilars) Injection Order Form

**Patient Name:** _____ **Date of Birth:** _____

**Patient Phone #:** _____ **Date:** _____

**Therapy Status:** ☐ New Start ☐ Continuation ☐ Restart **Last Dose:**_____

| Height (inches) | Weight (kg) | Allergies |
|---|---|---|
| | | |

## Diagnosis

ICD-10 Code(s): _____ J Code(s): _____

## Labs (Recommended to be done within 30 days of first dose)

- ☐ Labs to be reviewed or ordered by infusion center
  - ☑ Baseline
    - ☐ CMP
    - ☑ Glucose POC
  - ☑ Maintenance (every _____)
    - ☐ CMP
    - ☑ Glucose POC
- ☐ Labs reviewed by ordering provider, ok to proceed (Labs last done on _____)
- ☐ Other: _____

## Provider Information

Monitor patients for signs & symptoms of Inflammatory Bowel Disease (IBD), including patients without a history of IBD.
Teprotumumab may cause severe hearing impairment including hearing loss, which in some cases may be permanent. Assess patient's' hearing before, during, and after treatment and consider the benefit-risk of treatment with patients.

## Nursing Order

- ☑ Assess patients for elevated blood glucose and symptoms of hyperglycemia prior to infusion.
- ☑ Pregnancy status: If uncertain, obtain HCG urine test for women 11 – 50 years prior to treatment.

## Pre-Medications (Not routinely recommended, use only if clinically indicated)

- ☐ Acetaminophen 650 mg PO once
- ☐ Diphenhydramine 25 mg PO once
- ☐ Diphenhydramine 25 mg IV once
- ☐ Diphenhydramine 50 mg PO once
- ☐ Dexamethasone 20 mg IV once
- ☐ Dexamethasone 20 mg PO once
- ☐ Methylprednisolone 125 mg IV once
- ☐ Methylprednisolone 40 mg IV once

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- ☐ Diphenhydramine 50 mg IV once
- ☐ Other: _____
- ☐ Famotidine 20 mg IV once
- ☐ Famotidine 20 mg PO once

## IV Site Orders

- ☑ Follow standard protocol for IV site management
- ☑ In absence of standard protocol, follow the orders below:
  - ☑ Sodium chloride 0.9% infusion 250 mL IV at 20 mL/hr PRN (carrier fluid/KVO)
  - ☑ Start peripheral IV or access central line for infusion
  - ☑ Sodium chloride 0.9% 10 mL flush to IV site as needed
  - ☑ Heparin 50 units/5 mL flush to IV site as needed (central line only)
  - ☑ Heparin 500 units/5 mL flush to IV site as needed (central line only)
  - ☑ May use alteplase 2 mg intracatheter as needed for negative blood return of IV site

## Medication Orders

**Initial Dose**

☐ Teprotumumab 10 mg/kg (_____ mg) IV once over at least 90 minutes

**Maintenance Infusions:**

☐ Teprotumumab 20 mg/kg (_____ mg) IV once every 3 weeks for 7 doses after initial dose

**To be completed by Infusion Center staff only:**

Biosimilar substitution/Product Dispensed: _____ J-Code: _____
Rounded Dose: _____ mg

Rationale for Substitution:

- ☐ Payer-mandated substitution
- ☐ Financial stewardship
- ☐ Patient access / hardship

Pharmacy may substitute a biosimilar based on insurance coverage.
Pharmacy may adjust diluent, volume, and infusion duration in accordance with local practice standards.

## Administration Instructions

Administer first 2 infusions over at least 90 minutes. If well tolerated, the minimum time for subsequent infusions can be reduced to 60 minutes.

## Emergency / Hypersensitivity Orders

- ☑ Notify provider for next steps once patient stabilized
- ☑ Follow standard orders for management of allergies and anaphylaxis reactions
- ☑ In absence of standard protocol, follow the orders below:
  - ☑ Nursing to stop infusion, maintain airway, place supine, elevate legs, $O_2$ 2 L NC
  - ☑ Epinephrine 0.3 mg IM Once PRN anaphylaxis (first-line)

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- ☑ Diphenhydramine 25 mg IV q6h PRN itching/hives
- ☑ Hydrocortisone 100 mg IV Once PRN hypersensitivity
- ☑ Methylprednisolone 125 mg IV Once PRN hypersensitivity
- ☑ Famotidine 20 mg IV Once PRN hives/itching
- ☑ Albuterol inhaler 2 puffs Once PRN wheezing/SOB
- ☑ Normal Saline 1000 mL IV bolus Once PRN hypotension

## Infusion Center Staff

Please fax infusion records or discharge summary to: Fax Number _____

## Provider Information

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider NPI: _____

Provider Address: _____ Phone: _____ Fax: _____

***All orders are valid for 1 year from the ordered date unless otherwise indicated***