4704 Cahaba River Road, Suite 101-D, Birmingham. AL 35243

Phone (205) 739-2266   Fax (205) 490-8663   Bhaminfusion.com

TEPEZZA (Teprotumumab-Trbw) Order

Patient Name ____________________________ DOB _____________

Phone ___________________ Patient Weight _______ Height _______

*Please attach demographics and clinic notes.

DIAGNOSIS (Please provide ICD-10 code):

_____ Thyroid Eye Disease

PRE-MEDICATION (IF NEEDED):

_____ Tylenol 1000mg PO   _____ Solu-Cortef 100mg IVP _____ __________

_____ Pepcid 20mg IV PRN   _____ Benadryl 50mg PRN

ORDERS/DOSAGE:

_____ One infusion initially and then one every 3 weeks for a total of 8 infusions.

PHYSICIAN NOTES: ____

ORDERING PROVIDER (Print Name): ____________________________________

Signature: _____________________________________ Date: ________________

Phone: _______________________________ Fax: ___________________________