
 <p style="text-align: center;">Oregon Health & Science University Hospital and Clinics Provider's Orders</p> <div style="display: flex; align-items: center;"> <div style="writing-mode: vertical-rl; transform: rotate(180deg); font-size: small; margin-right: 5px;">PO7071</div>  </div> <p style="text-align: center;">ADULT AMBULATORY INFUSION ORDER Teprotumumab-trbw (TEPEZZA) Infusion</p> <p style="text-align: center; font-size: small;">Page 1 of 4</p>	<p>ACCOUNT NO. MED. REC. NO. NAME BIRTHDATE</p> <p style="text-align: right; font-size: small;"><i>Patient Identification</i></p>
ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.	

Weight: _____ kg **Height:** _____ cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note.**
2. May cause fetal harm when administered to a pregnant woman. Counsel patients on appropriate forms of contraception prior to initiation, during treatment and for 6 months following the last dose.
3. Advise patients of risk of exacerbation of inflammatory bowel disease (IBD). Patients with IBD should be monitored for disease flares. If IBD exacerbation is suspected, consider discontinuation.

LABS:

- HCG Beta Quant Plasma, Routine, ONCE, Do not hold infusion for result, OK to proceed with infusion as long as urine HCG is negative.
- HCG Qual Urine, Routine, ONCE, every visit
Do not administer until negative pregnancy evaluation performed for women of childbearing potential.
- Basic Metabolic Set, Routine, ONCE, every 12 weeks for 2 treatments.
- Hemoglobin A1C, Routine, ONCE, every 12 weeks, Do not need to wait for results prior to infusion.
- Labs already drawn. Date: _____

NURSING ORDERS:

1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, dec clotting (alteplase), and/or dressing changes.
2. Hold infusion until negative pregnancy evaluation performed for women of childbearing potential.
3. Hold infusion and contact provider if blood glucose greater than 200 mg/dL prior to 1st and 5th infusions.
4. Contact provider if any concerns of adverse drug reactions.
5. First and second infusion: monitor patient for infusion-related reactions for 30 minutes after completion of teprotumumab-trbw infusion.
6. Obtain vital signs prior to and after teprotumumab-trbw infusion complete, and as needed for infusion related reaction management.



Oregon Health & Science University
Hospital and Clinics Provider's Orders

ADULT AMBULATORY INFUSION ORDER
**Teprotumumab-trbw (TEPEZZA)
Infusion**

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PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)

- NURSING COMMUNICATION – In patients who experience an infusion reaction, administer pre-medication and administer all subsequent infusions at a slower infusion rate.
- acetaminophen (TYLENOL) tablet, 650 mg, oral, AS NEEDED for previous infusion-related reaction, every visit
- loratadine (CLARITIN) tablet, 10 mg, oral, AS NEEDED for previous infusion-related reaction, every visit
(Give either loratadine or diphenhydrAMINE, not both.)
- diphenhydrAMINE (BENADRYL) capsule, 25 mg, oral, AS NEEDED for previous infusion-related reaction, every visit
(Give either diphenhydrAMINE or loratadine, not both.)
- methylPREDNISolone sodium succinate (SOLU-MEDROL), 100 mg, intravenous, AS NEEDED for previous infusion-related reaction, every visit

MEDICATIONS:

Initial Doses

First Dose:

- teprotumumab-trbw (TEPEZZA) 10 mg/kg in sodium chloride 0.9%, intravenous, ONCE, over 90 minutes.

Second Dose: (3 weeks after first dose)

- teprotumumab-trbw (TEPEZZA) 20 mg/kg in sodium chloride 0.9%, intravenous, ONCE, over 90 minutes.

Maintenance Doses

Third and Subsequent Doses: (starting 3 weeks after second dose)

- teprotumumab-trbw (TEPEZZA) 20 mg/kg in sodium chloride 0.9%, intravenous, ONCE, If no previous reactions, may reduce infusion time to 60 minutes. If previous reactions, infuse over 90 minutes.

Interval:

- Every 3 weeks for 6 doses



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AS NEEDED MEDICATIONS:

1. ondansetron (ZOFRAN) injection, 4 mg, intravenous, AS NEEDED x1 dose, for nausea/vomiting. Administer over at least 30 seconds, preferably over 2-5 minutes.
2. acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for pain

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

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 _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____
Printed Name: _____ **Phone:** _____ **Fax:** _____



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Central Intake:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient's preferred clinic location:

Beaverton

OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006

Phone number: 971-262-9000

Fax number: 503-346-8058

NW Portland

Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210

Phone number: 971-262-9600

Fax number: 503-346-8058

Gresham

Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030

Phone number: 971-262-9500

Fax number: 503-346-8058

Tualatin

Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062

Phone number: 971-262-9700

Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders