Thyrotropin alfa (THYROGEN) Injection

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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. Thyrogen should only be used by providers knowledgeable in the management of patients with thyroid cancer
3. If Thyrogen is administered with radioiodine, the warnings, precautions, and contraindications for radioiodine also apply to this combination regimen.
   Thyrogen is further contraindication in pregnancy and patients who are breastfeeding.
4. Thyrogen-Induced Hyperthyroidism: Patients with substantial thyroid tissue *in situ* or functional thyroid cancer metastases are at risk of transient (over 7 to 14 days) but significant rise in serum thyroid hormone stimulation. Increased risk for Thyrogen- Induced Hyperthyroidism include the elderly and those with a known history of heart disease. Consider hospitalization for administration of Thyrogen and post-administration observation in patients at risk.
5. Stroke occurring within 72 hours after Thyrogen administration has been observed in post-marketing reports in patients without known central nervous system metastases, the majority of which were young women taking oral contraceptives at time of the event or had other risk factors (e.g. smoking history, migraines). Patients should be well hydrated prior to Thyrogen treatment.
6. Sudden, rapid, and painful enlargement of residual thyroid tissue or distant metastases can occur following Thyrogen treatment. Pre-treatment with corticosteroids should be considered for patients in whom tumor expansion may compromise anatomic structures.
7. Scheduling Considerations: Oral radioiodine should be administered 24 hours following the second thyrotropin alfa injection (for diagnostic scanning and remnant ablation). Perform diagnostic scanning 48 hours after radioiodine administration (72 hours after the second thyrotropin alfa injection).

LABS:

□ THYROGLOBULIN IMA OR RIA WITH AB, Routine, ONCE

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NURSING ORDERS:

1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes
2. Select one:

☐ Thyrogen injection for Diagnostic Imaging: obtain serum Tg sample 72 hours after second Thyrogen injection.

☐ Thyrogen injection for Thyroid Tissue Remnant Ablation: obtain Tg sample 24 hours after second Thyrogen injection).

3. Do not administer IV

PRE-MEDICATIONS:

☐ prednisone (DELTASONE) tablet, 40 mg, by mouth, ONCE, every visit

MEDICATIONS:

- Thyrotropin alfa (THYROGEN) injection, 0.9 mg, intramuscular, daily for 2 doses

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 (Policy HC-PAT-133-GUD). 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 reaction.
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity reaction.
4. Hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction. Dilute vial by either pressing chamber for Act-O-Vial or diluting powder vial with 2 mL SWFI or NS for injection.
5. Famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose, for hypersensitivity 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.

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Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

INFUSION REFERRAL TEAM Phone (providers only) (971) 262-9645 Fax completed orders to (503) 346-8058 *Infusion orders located at:* *www.ohsuknight.com/infusionorders*	☑ **Please indicate the patient's preferred clinic location below**	
	☐ **BEAVERTON** OHSU Knight Cancer Institute	15700 SW Greystone Court Beaverton OR 97006
	☐ **NW PORTLAND** Legacy Good Samaritan campus	Medical Office Building 3 – Suite 150 1130 NW 22nd Ave, Portland OR 97210
	☐ **GRESHAM** **Legacy Mount Hood campus**	Medical Office Building 3 – Suite 140 24988 SE Stark, Gresham OR 97030
	☐ **TUALATIN** **Legacy Meridian Park campus**	Medical Office Building 2 – Suite 140 19260 SW 65th Ave, Tualatin OR 97062