CIVIC INFUSION

FAX: 203-724-4838

249 Danbury Rd, Wilton, CT 06897
400 Columbus Ave, Valhalla, NY 10595
127 Washington Ave, N. Haven, CT 06473
_____

(teprotumumab-trbw)

TEPEZZA infusion orders

Patient Name _____ DOB _____

Phone _____ M F

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Thyroid Eye Disease
- ☐ _____ _____

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____

TEPEZZA ORDERS

DOSAGE

First Dose - _____ mg/kg

Dose 2-8 - _____ mg/kg

PATIENT WEIGHT

_____lbs.

_____kg

HEIGHT

_____ft _____in

FREQUENCY

Every 3 weeks for 8 visits

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____