Local Infusion

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TZIELD (TEPLIZUMAB-MZWV) ORDER FORM

PATIENT INFORMATION

Patient Name: ______________________________ DOB: ____________

Mobile Number: ____________________ Patient Weight: ____________________

Allergies: ____

DIAGNOSIS (Provider must specify)

❑ Stage 3 Type 1 Diabetes in adults, ICD 10: E10.____________________

❑ Stage 2 Type 1 Diabetes in pediatric patients 8 years or older, ICD 10: E10.____________________

PROVIDER INFORMATION

Provider Name (print name): ____________________ Provider NPI: ____________

Signature: ______________________________ Date: ____________

Contact Name: ____________________ Phone: ____________ Fax: ____________

Email Address: ____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (**recommended on bottom)

❑ Acetaminophen (Tylenol) 500 mg PO

❑ Famotidine 20 mg IV

❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Benadryl 25mg PO

❑ Cetirizine (Zyrtec) 10 mg PO

❑ Other: ____________________ Dose: ____________ Route: ____________

**Recommended pre-medications: (1) a nonsteroidal anti-inflammatory drug (NSAID) or acetaminophen, (2) an antihistamine, and/or (3) an antiemetic before each TZIELD dose for at least the first 5 days of the 14-day treatment course.

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Tzield	❑ Day 1: 65 mcg/m2; Day 2: 125 mcg/m2; Day 3: 250 mcg/m2; Day 4: 500 mcg/m2; Days 5 through 14: 1,030 mcg/m2	❑ IV	❑ every day for 14 days

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): ____________

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: ❒ CT: 203.433.0621 ❒ ME: 207.407.7272 ❒ NH: 603.217.5371 ❒ NJ: 201.581.4521

Order valid for 1 year from date of signature unless otherwise specified here: ____________