FAX: 725.228.5220 eMediate INFUSION

TZIELD

☐ New Prescription/Referral
☐ Prescription Refill

 # Of Refills:

PATIENT INFORMATION

*Patient Insurance & ID (front and back) are needed

Name:	DOB:	Weight: kg

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	*Email (for the referral update):	
Clinic:	Address:	
NPI:		
Patient's PCP Name:	Phone:	Fax:
Clinic:	Address:	
NPI:		

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Tzield:
(teplizumab)

☐ Infuse Tzield IV daily for 14 days according to the following dosing regimen:

☐ DAY 1: 65 mcg/m^2 ☐ DAY 2: 125 mcg/m^2 ☐ DAY 3: 250 mcg/m^2

☐ DAY 4: 500 mcg/m^2 ☐ DAY 5 through 14: 1,030 mcg/m^2

☐ Others: _____

_____

Patients should be pre-medicated with APAP or NSAID, antihistamine, and/or an anti-emetic for 1st 5 doses

Pre-Medication:

☐ Acetaminophen _____mg PO ☐ Ibuprofen _____mg PO ☐ Toradol 30mg IV

☐ Diphenhydramine 25mg PO ☐ Cetirizine 10mg PO ☐ Loratadine 10mg PO

☐ Zofran _____mg IV ☐ Cetirizine 10mg IV ☐ Other:_____

ANA Kit Protocol:

☐ OK to use

☐ Administer pre-meds for: ☐ First 5 doses only ☐ Prior to all doses ☐ Other:_____

☐ Other Orders: _____

Dx: **Diagnosis:** ☐ Type 1 diabetes mellitus with unspecied complications (ICD-10: E10.8)

☐ Type 1 diabetes mellitus without complications (ICD-10: E10.9)

Other:_____ **ICD-10:** _____

PRESCRIBER SIGNATURE: x Date (Valid for 1 year):

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

Please include the following

☐ Patient demographics ☐ Insurance attached ☐ Diagnosis(supporting) ☐ History & Physical
☐ Lab Results ☐ Clinical progress notes ☐ Medication list ☐ Other Test Results
☐ Baseline CBC w/differential & LFTs - attach results ☐ Pancreatic islet cell autoantibodies
☐ Documentation of dysglycemia without overt hyperglycem