New Prescription/Referral Prescription Refill

Of Refills:

Rx: Patient N	Name:		Patient Weight: kg	<u>OB:</u>
T 7151 D	Infuse Tzield IV daily for 14 days according to the following dosing regimen:			
TZIELD: (teplizumab)	DAY 1: 65 mcg/m ²	DAY 2: 125 mg	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	on:			ANA Kit Protocol:
Acetaminopher	ımg PO Ibuprofen	mg PO Tor	adol 30mg IV	OK to use
Diphenhydram	ine 25mg PO Cetirizine	10mg PO Lor	ratadine 10mg PO	
Zofranmg IV Cetirizine 10mg IV Other:				
Administer pre-meds for: First 5 doses only Prior to all doses Other:				
Other Orders:				
Diagnosis: Type 1 diabetes mellitus with unspecified complications (ICD-10: E10.8) Type 1 diabetes mellitus without complications (ICD-10: E10.9)				
• •		_	ICD-10:	
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Physician Signature		NF	PI#: DA	TE:(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. PHYSICIAN INFORMATION				
Physician Name:	RWATION		Clinic:	
Phone:	Fax:	Email:	Other:	
Office Mailing Address:				
Please include	*Patient demographics *I	nsurance attached	*Diagnosis(supporting)	*History & Physical
<u>the following</u>	*Lab Results *C	linical progress notes	*Medication list	*Other Test Results
*Baseline CBC w/differential & LFTs - attach results *Pancreatic islet cell autoantibodies				
*Documentation of dysglycemia without overt hyperglycemia				