Horizon Infusions

Tzield® (teplizumab-mzwv)

Select location:

- ☐ Akron
- ☐ Anderson
- ☐ Athens
- ☐ Canton
- ☐ Cincinnati (Blue Ash)
- ☐ Cincinnati (West Side)
- ☐ Cleveland (Mayfield)
- ☐ Cleveland (North Olmsted)
- ☐ Columbus (East Broad)
- ☐ Columbus (Hilliard)
- ☐ Columbus (Worthington)
- ☐ Dayton (Beavercreek)
- ☐ Dayton (Englewood)
- ☐ Findlay
- ☐ Liberty
- ☐ Lima
- ☐ Mansfield
- ☐ Mentor
- ☐ Perrysburg
- ☐ Sandusky
- ☐ Solon
- ☐ Springfield
- ☐ Toledo
- ☐ Troy
- ☐ Warren
- ☐ Youngstown
- ☐ Zanesville
- ☐ Crestview Hills (KY)

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to 888-977-0914

Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name: | **DOB:**

Phone: | **Other Phone:**

Email:

Social Security #: | **Allergies:**

Gender: ☐ M ☐ F | **Weight:** ☐ Lbs ☐ Kg

Patient Status: ☐ New to therapy ☐ Continuing therapy ☐ Next due date ***(if applicable)***:

2. INSURANCE INFORMATION (*required*)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name: | **NPI#:**

License #: | **TIN#:** | **DEA#:**

Address:

City: | **State** | **Zip**

Office Contact: | **Email:**

Office phone: | **Office fax:**

4 . DIAGNOSIS INFORMATION (ICD 10 Code *Required*)

☐ Type 1 diabetes mellitus with unspecified complications (_____)

☐ Type 1 diabetes mellitus without complications (_____)

☐ Other _____

5 . PRESCRIPTION INFORMATION (*requires new order every 12 months*)

☐ Infuse Tzield IV daily for 14 days according to the below 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

☐ Vital signs per HI Protocol

☐ Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS ☐ N/A

- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
- ☐ Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
- ☐ Diphenhydrimine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV (requires driver)
- ☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 80mg ☐ 125mg IV
- ☐ Prednisone _____ mg PO
- ☐ Other _____

POST-MEDICATIONS ☐ N/A

- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
- ☐ Prednisone _____ mg PO
- ☐ Other _____

6. LABS

☐ Baseline CBC & LFTs (required)
Baseline hold parameters: Lymphcyte count <1,000/mcL, Hgb <10g/dL, Platelets <150,000/mcL, ANC <1,500/mcl, ALT/AST >2x ULN, or bilirubin >1.5x ULN

☐ Repeat CBC & LFTs every ____ day(s)
Notify physician for abnormal labs.
Discontinue treatment for AST/ALT >5x ULN or bilirubin > 3x ULN
Discontinue treatment for prolonged lymphopenia (<500/mcL) lasting 1 week or longer

Required labs to be drawn by: ☐ Horizon Infusions ☐ Referring physician

☐ CBC w/Diff	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ CRP	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ CMP	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ ESR	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ Hepatic Panel	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ Renal Panel	☐ Each Infusion	☐ Other Frequency (*specify*): _____

☐ Quantiferon TB Gold, annually, last completed *(date)*: _____

☐ Other (*specify*):_____

7. SIGNATURE (required)

_____ _____

PHYSICIAN'S SIGNATURE **DATE**