



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

**Fax completed form to (724) 240-1586**

Phone (724) 510-3702

**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 (\_\_\_\_\_)      Other \_\_\_\_\_  
 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<sup>2</sup>
- Day 2: 125 mcg/m<sup>2</sup>
- Day 3: 250 mcg/m<sup>2</sup>
- Day 4: 500 mcg/m<sup>2</sup>
- Day 5 through 14: 1,030 mcg/m<sup>2</sup>

Vital signs per HI Protocol

Anaphylaxis & Hydration Management per HI Protocol

<b>PRE-MEDICATIONS</b>	N/A			
Acetaminophen	500mg	650mg	1000mg	
Fexofenadine (Allegra)	180mg PO	(or other non-sedating antihistamine)		
Diphenhydramine (Benadryl)	25mg	50mg	PO	IV (requires driver)
Methylprednisolone (Solu-Medrol)	40mg	80mg	125mg	IV
Prednisone	_____ mg PO			
Other	_____			
<b>POST-MEDICATIONS</b>	N/A			
Acetaminophen	500mg	650mg	1000mg	
Prednisone	_____ mg PO			
Other	_____			

**6. LABS**

Baseline CBC & LFTs (required)

Baseline hold parameters: Lymphocyte 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 \_\_\_\_\_