Tzield® (teplizumab-mzwv)

Horizon Infusions

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

Fax completed form to (315) 457-4305

Phone (315) 457-3091

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**