Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Preferred clinic: _____	**DAYS IN AIC**: _____	**DAYS IN HOME**: _____

Rev. 4.29.25

Tzield® (teplizumab-mzwv) Plan of Treatment

PATIENT DEMOGRAPHICS:

Patient Name:		Patient's Phone:			
Date of Birth:		Address:			
Allergies:		City, State, Zip:			
Height in inches:	Weight: LB or KG	Gender:	Allergies:	☐ See list	☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐ E10.9 - Type 1 diabetes mellitus without complications ☐ _____-Other: _____

☐ E10.8 - Type 1 diabetes mellitus with unspecified complications

REQUESTED DOCUMENTATION:

1	Insurance information
2	H&P including tried and failed therapies
3	Full medication list
4	**Required: Recent CBC with diff and LFTs**

HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE? Yes or No

PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

HOME SUPPLY ORDER: *Applicable to all home infusion patients subject to insurance approval

All supplies for vascular access line care, dressing kit, drug administration, adverse reaction kit, Infusion pump, IV pole, pole clamp etc. will be

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive teplizumab-mzwv if receiving antibiotics for active infectious process, active fever and/or suspected infection or surgery. If patient experiences severe cytokine release syndrome, consider temporarily pausing therapy for 1-2 days and review prescribing information before continuing therapy.

☑ **Home Anaphylaxis Kit:** Dispense and administer for mild and severe reaction. Applicable to all home infusion patients.

2 - Epinephrine 1 mg/ml 1 ml
2- Diphenhydramine 50 mg/ml 2 ml vial
Syringes, needles and 0.9% Normal Saline Flushes 10 mls to administer
Complete Home Infusion Physician Standing Order for complete Home Infusion, Nursing, and Adverse Reaction Orders to be utilized in the event of an adverse reaction/anaphylaxis.
Epinephrine administered IM per weight based dosing guide and Benadryl 25-50mg IVP to be administered by clinician in the home.

***Per FDA labeling: Premedication of Acetaminophen or NSAID and antihistamine, and/or an antiemetic is suggested for at least the first 5 days of the 14-day treatment course**

***Any selected premedication will only be given with infusions 1 through 5 unless otherwise designated here:** _____

IV

Diphenhydramine	☐ 25mg	☐ 50mg	
Methylprednisolone	☐ 40mg	☐ 125mg	
Ondansetron	☐ 4mg	☐ 8mg	
Other:	☐		

PO

Acetaminophen	☐ 325mg	☐ 500mg	☐ 650mg	☐ 1000mg
Famotidine	☐ 20mg	☐ 40mg	
Diphenhydramine	☐ 25mg	☐ 50mg	
Fexofenadine	☐ 60mg	☐ 180mg	
Cetirizine	☐ 10mg	
Loratadine	☐ 10mg	
Other:	☐	

DOSAGE:

☑

Treatment Day	Dosage
Day 1	65 mcg/m2
Day 2	125 mcg/m2
Day 3	250 mcg/m2
Day 4	500 mcg/m2
Day 5-14	1030 mcg/m2

LAB ORDERS:

☐ Draw CBC with diff & LFT on infusion days 5 and 8

☐ Other: _____

MEDICATION:

☑ Tzield® dose to be diluted in 25ml NS administered as an IV infusion over a minimum of 30-minutes. Administer once daily for 14 consecutive days.

Follow first 5 infusions with a 1-hour post infusion observation.

Physician responsible for all follow up lab monitoring.

Per FDA labeling, with AST/ALT > 5x ULN, bilirubin > 3x ULN, or Lymphocyte count <500/mcL lasting one week or longer, patient may be ineligible to receive Tzield®

SPECIAL/OTHER LAB ORDERS:

☐ _____

_____

SITE OF CARE:

☐ AIC ☐ AIC and Home with a nurse

**If site of care not indicated, PIS will coordinate with patient*

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC
☑ Flush PIV/Access per PIV/PICC/CVC protocol.
☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated.

Dispense and Administer as Prescribed

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures) **DATE:**

Dispense as written/Brand medically necessary	Substitution permitted	

Palmetto INFUSION

Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- ☐ **Patient demographics - address, phone number, SS#, etc.**
- ☐ **Insurance information - copy of the card(s) if possible**
- ☐ **Plan of Treatment/Orders**
- ☐ **Most recent physician office notes to include tried and failed therapies - all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- ☐ **Any lab results or other diagnostic procedures to support the diagnosis.**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.palmettoinfusion.com