INTRAMED Plus
infusion services

TZIELD®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ Type 1 diabetes mellitus w/unspecified complications ICD-10 Code: E10.8
_____ Type 1 diabetes mellitus without complications ICD-10 Code: E10.9
_____ Other:_____ ICD-10 Code: _____

Allergies:_____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes supporting primary diagnosis
  - Appropriate documentation to confirm Stage 2 type 1 diabetes
  - Confirmation that clinical history does NOT suggest type 2 diabetes mellitus
- Recent Lab Results including:
  - CBC & LFTs
  - Two (2) Positive (+) pancreatic islet autoantibodies tests
  - OGTT
- Medication List

Patient
Weight: _____ lbs.
Height:_____ in.

TZIELD® (teplizumab-mzwv) J Code: J9389

4. Drug Order:

❑ Administer dose over at least 30 minutes once daily for 14 consecutive days using BSA as follows:

Day 1: 65 mcg/m^2.
Day 2: 125 mcg/m^2.
Day 3: 250 mcg/m^2.
Day 4: 500 mcg/m^2.
Days 5 through 14: 1,030 mcg/m^2.

Doses authorized: 14*

*Infusion days 1-5 administered in the infusion center (5 doses total); days 6-14 may be administered in the home – if patient's insurance covers home administration additional orders to be provided for completion

Pre-Medication Orders: **NSAID/acetaminophen, antihistamine, and/or antiemetic required for the first 5 days**
Acetaminophen 650 mg PO and Diphenhydramine 25 mg PO
Administered 30 min prior to infusion *Adjust to patient's needs

❑ Other orders: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name with Credentials:_____ NPI: _____

FAX ALL INFORMATION	INFUSION CENTER LOCATIONS
CENTRAL FAX **803.999.1754**	COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 803.999.1760