TZIELD® (Teplizumab) Prescriber Order and Referral Form

Pharmacists with the Froedtert Pharmacy will be supporting this patient's infusion medication management.

Fax completed form, insurance information and clinical documentation to 414-260-7368.

Patient Name: ______________________________ Date of Birth: ____________________

Address: ____

Phone: ____________________ Height: __________ ☐ inches ☐ cm Weight: __________ ☐ lbs ☐ kg

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Treatment Date ____________________

Clinical Information

Diagnosis: ☐ Type 1 diabetes mellitus with unspecified complications (ICD-10: EI0.8)

☐ Type 1 diabetes mellitus without complications (ICD-10: EI0.9)

☐ Other: ______________________________ ICD-10 Code(s): ____________________

TZIELD (Teplizumab) Prescription

☐ **Infuse TZIELD IV daily for 14 days according to the following dosing regimen:**

- Day 1: 65 mcg/m2
- Day 2: 125 mcg/m2.
- Day 3: 250 mcg/m2
- Day 4: 500 mcg/m2
- Day 5 through 14: 1,030 mcg/m2

Ancillary Orders

Anaphylaxis Orders

☐ Treat per Froedtert Home and Specialty Infusion protocol.

Medication Orders

☐ Acetaminophen _______ mg PO
☐ Diphenhydramine 25 mg PO
☐ Zofran _______ mg IV
☐ Ibuprofen _______mg PO
☐ Cetirizine 10mg PO
☐ Cetirizine 10mg IV
☐ Toradol 30mg IV
☐ Loratadine 10mg PO
☐ Other: ____________________

Administer pre-meds for: ☐ First 5 doses only ☐ Prior to all doses ☐ Other: ____________________

IV Access and Flush Orders: RN to access and monitor venous infusion line as indicated below:

☐ Peripheral: Flush with 0.9% NS - 10 ml pre/post-use.

☐ Implanted Port or PICC: Flush with 0.9% NS - 10 ml pre/20 ml post-use and 10 ml pre/20 ml post-lab

■ Central venous catheter care maintenance and dressings changes weekly and PRN per the Froedtert protocol

☐ Remove PICC line after last TZIELD infusion has been completed.

Lab Orders

☐ Baseline CBC & LFTs (required)

Baseline hold parameters: Lymphocyte count <1,000/mcL, Hgb <I0g/dL, Platelets <150,000/mcL, ANC <1,500/mcL, ALT/ AST > 2x ULN, or bilirubin > I.5x ULN D

☐ 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: ☐ Froedtert Home and Specialty Infusion ☐ Referring physician

Skilled nurse to assess and administer via access device as indicated above. Nurse will provide ongoing support as needed.
Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

______________________________ Prescriber Signature ____________ Date ____________ Time

______________________________ Prescriber Name ____________ Phone ____________ Fax

______________________________ Address ____________ NPI

______________________________ City, State, Zip ____________ Office Contact

Original - Medical Records

Froedtert Home and Specialty Infusion
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