BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

TZIELD (TEPLIZUMAB)
INFUSION ORDERS

FAX: 470.922.3656 | **PHONE:** 470.377.6400

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 470.922.3656

Patient Name: _____ DOB: _____ Phone: _____

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

MEDICAL INFORMATION

Diagnosis: ☐ Type 1 diabetes mellitus with unspecified complications (ICD-10: E10.8)

☐ Type 1 diabetes mellitus without complications (ICD-10: E10.9)

☐ Other: _____ **ICD-10 code:** _____

Patient Weight: _____ lbs. (required) Patient Height: _____ inches (required)

Allergies: _____

THERAPY ORDER

☐ Infuse Tzield IV daily for 14 days according to the following 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

Patients should be pre-medicated with APAP or NSAID, antihistamine, and/or an anti-emetic for 1st 5 doses

Pre-medication orders:

☐ Acetaminophen _____ mg PO ☐ Ibuprofen _____ mg PO ☐ Toradol 30mg IV

☐ Diphenhydramine 25 mg PO ☐ Cetirizine 10mg PO ☐ Loratadine 10mg PO

☐ Zofran _____ mg IV ☐ Cetirizine 10mg IV ☐ Other: _____

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

Lab orders:

☐ 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 physican 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: ☐ Biocare Infusion ☐ Referring physician

Other orders: _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Biocare Infusion,* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Biocare Infusion selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

BIOCARE INFUSION
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COMPREHENSIVE SUPPORT FOR TZIELD THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes (H&P) to support primary diagnosis - Including:
  - ☐ Does the patient have a at least two positive pancreatic islet cell autoantibodies?
    - ☐ Yes ☐ No If yes, please indicate: _____
  - ☐ Does the patient have dysglycemia without overt hyperglycemia? ☐ Yes ☐ No
  - ☐ Patient does not have a clinical history to suggest type 2 diabetes
  - ☐ Patient does not have an acute infection with Epstein-Barr Virus or Cytomegalovirus
- ☐ Supporting labs/tests
  - ☐ Oral glucose tolerance test (if available)
  - ☐ Lab results indicating pancreatic islet cell autoantibodies
- ☐ Other medical necessity: _____

REQUIRED PRE-SCREENING

- ☐ **Baseline CBC & LFTs - attach result**
- ☐ **Pancreatic islet cell autoantibodies**
- ☐ **Documentation of dysglycemia without overt hyperglycemia**

Biocare Infusion will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (470) 922-3656 or call (470) 377-6400 for assistance