Provider Order Form

TZIELD (TEPLIZUMAB-MZWV)

Uptiv Health

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: ☐ lbs ☐ kg

Allergies: _____ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Stage 3 Type 1 Diabetes in adults E10. _____ ☐ Other: _____

☐ Stage 2 Type 1 Diabetes in pediatric patients 8 years or older E10. _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg

☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg

☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg

☐ Cetrizine (Zyrtec) 10 mg PO

☐ Other: _____

**Recommended pre-medications: (1) a nonsteroidal anti-inflammatory drug (NSAID) or acetaminophen, (2) an antihistamine, and/or (3) an antiemetic before each TZIELD dose for at least the first 5 days of the 14-day treatment course.

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☒ (Teplizumab-Mzwv), IV	☒ Day 1: 65 mcg/m2 Day 2: 125 mcg/m2 Day 3: 250 mcg/m2 Day 4: 500 mcg/ m2 Days 5 through 14: 1,030 mcg/m2	☒ every day for 14 days

☒ Flush with 0.9% sodium chloride at infusion completion.

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ CRP ☐ at each dose ☐ every _____

☐ Other _____ ☐ at each dose ☐ every _____

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX

Provider Signature Date