TZIELD INFUSION ORDER (TEPLIZUMAB)

INFUSIONMED | USA
LIVING YOUR BEST LIFE. ONE DROP AT A TIME.

Date: ____/____/_____

PATIENT INFORMATION

Patient Name:_____ DOB:___/____/____ Phone: _____

Height (Required): _____ Inch/Cm/Ft. Weight (Required):_____ lbs/kg

Allergies: _____

MEDICAL INFORMATION

ICD-10 & Diagnosis:

- ☐ E108: Type 1 diabetes mellitus with unspecified complications
- ☐ E10.9: Type 1 disbetes mellitus without complications
- ☐ Other : _____

TZIELD THERAPY ORDER

- ☐ TZIELD IV for 14 days as per dosage guideline:
  Day 1: 65mcg/m2 Day 2: 125mcg/m2 Day 3: 250mcg/m2
  Day 4: 500mcg/m2 Day 5 to 14: 1030mcg/m2
- ☐ Other:_____

Pre-medication:
- ☐ Acetaminophen_____mg
- ☐ Other: _____

Start Date of Infusion: ___/___/___ End Date: ___/___/___

PROVIDER INFORMATION

Provider's Name: _____

Provider's NPI: _____ Signature: _____

Phone: _____ Fax: _____ Date: _____/_____/_____

Office Address: _____

Email Address: _____ Contact Person: _____

PLEASE FAX COMPLETED FORM, CLINICAL DOCUMENTATION, DEMOGRAPHICS & COPY OF INSURANCE CARD

PHONE: 972-810-0990 | FAX: 972-810-0994