

Contact Info:

Phone:

Fax:

ONBOARDING REQUIREMENTS FOR TZIELD:

- Confirmation of Stage 2 T1D as evidenced by at least 2 positive pancreatic islet cell autoantibodies
 - Glutamic acid decarboxylase 65 (GAD) autoantibodies
 - Insulin autoantibody (IAA)
 - Insulinoma-associated antigen 2 autoantibody (IA-2A)
 - Zinc transporter 8 autoantibody (ZnT8A)
 - Islet cell autoantibody (ICA)
- Dysglycemia without overt hyperglycemia using an oral glucose tolerance test (or alternative test)
- Completion of complete blood count, complete metabolic panel; Epstein-Barr Virus (EBV) and cytomegalovirus (CMV) testing
- Completion of age-appropriate vaccinations.

 Location: Home Office Chartwell Ambulatory Infusion Suite (Pittsburgh, PA only) Date: _____ Start of Care Date: _____

PATIENT INFORMATION: Please include face sheet, H&P, clinicals, and any available labs results.

Patient Name:			Patient DOB:		
Phone:	Cell:	Email:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	Relationship:		

INSURANCE INFORMATION

Primary Insurance:	Policy #:	Group #:	Insured:
Secondary Insurance:	Policy #:	Group #:	Insured:

CLINICAL INFORMATION

Height: _____ (inches/cm)	Weight: _____ (lbs/kg)	BSA: _____ (m ²)
Medication Allergies & Reactions:		

PREMEDICATIONS

Antipyretic (select one): <input type="checkbox"/> Acetaminophen: Patients ≥12 years: 650 mg PO <input type="checkbox"/> Ibuprofen: Patients ≥12 years: 400 mg PO <input type="checkbox"/> Other:	Antihistamine (select one): <input type="checkbox"/> Diphenhydramine: Patients ≥12 years: 25 mg PO <input type="checkbox"/> Cetirizine: 10 mg PO <input type="checkbox"/> Famotidine: Patients ≥12 years: 20 mg PO <input type="checkbox"/> Other:	Antiemetic (select one): <input type="checkbox"/> Ondansetron: Patients ≥12 years: 4 mg PO <input type="checkbox"/> Prochlorperazine: Patients ≥12 years: 5 mg PO <input type="checkbox"/> Other:
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 Administer 30 minutes prior to infusion on: Days 1 through 5 only Days 1 through 14 Other:

TZIELD

TZIELD IV daily (rounded to nearest 10 mcg): Day 1: 65 mcg/m ² Day 4: 500 mcg/m ² Day 2: 125 mcg/m ² Days 5 through 14: 1030 mcg/m ² Day 3: 250 mcg/m ²	Dose will be administered over minimum allowable per package insert, or longer as clinically indicated: <input type="checkbox"/> MD Office/Clinic on Days: _____ <input type="checkbox"/> Chartwell AIS on Days: _____ <input type="checkbox"/> Home on Days: _____
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LABS

<input type="checkbox"/> LFTs <input type="checkbox"/> CBC with diff/PLT <input type="checkbox"/> BMP <input type="checkbox"/> Other:	Frequency:
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EMERGENCY MEDICATIONS
 Chartwell Anaphylaxis Kit per protocol (for patients ≥18 years) Other:

IV LINE CARE & MONITORING

- Line care per Chartwell protocol and 0.9% NaCl 25 mL post-infusion flush
- Remote vital sign monitoring for signs and symptoms of Cytokine Release Syndrome on Days 1 through 5 or until temperature WNL x48 hours
- Remove IV line after last dose

PHYSICIAN INFORMATION

Name:	NPI:
Phone:	Fax:

By signing, I certify/recertify that the above therapy products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

Physician Signature:	Date:
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