TZIELD PEDIATRIC FORM

CHARTWELL Pharmacy

Contact Info:

Phone:	Fax:

ONBOARDING REQUIREMENTS FOR TZIELD:

- Confirmation of Stage 2 TID 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: (m²)
Medication Allergies & Reactions:		

PREMEDICATIONS

Antipyretic (select one):	**Antihistamine** (select one):	**Antiemetic** (select one):
☐ Acetaminophen: Patients ≥12 years: 650 mg PO Patients <12 years: 15 mg/kg (max: 650 mg) PO	☐ Diphenhydramine: Patients ≥12 years: 25 mg PO Patients <12 years: 1 mg/kg (max: 25 mg) PO	☐ Ondansetron: Patients ≥12 years: 4 mg PO Patients <12 years: 0.15 mg/kg (max: 4 mg)
☐ Ibuprofen: Patients ≥12 years: 400 mg PO Patients <12 years: 10 mg/kg (max: 400 mg) PO	☐ Cetirizine: 10 mg PO ☐ Famotidine: Patients ≥12 years: 20 mg PO Patients <12 years: 0.5 mg/kg (max: 20 mg)	☐ Prochlorperazine: Patients ≥12 years: 5 mg PO Patients <12 years: 0.1 mg/kg (max: 5 mg) PO
☐ Other:	☐ Other:	☐ Other:

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/m2 • Day 2: 125 mcg/m2 • Day 3: 250 mcg/m2 • Day 4: 500 mcg/m2 • Days 5 through 14: 1030 mcg/m2

Dose will be administered over minimum allowable per package insert, or longer as clinically indicated:

☐ MD Office/Clinic on Days: ______________ ☐ Chartwell AIS on Days: ______________ ☐ Home on Days: ______________

LABS

☐ LFTs ☐ CBC with diff/PLT ☐ BMP ☐ Other: Frequency:

EMERGENCY MEDICATIONS

☐ Chartwell Anaphylaxis Kit per protocol (for patients ≥18 years) ☐ Other:

☐ Pediatric emergency medication recommendations:

FOR HYPERSENSITIVITY: Hold infusion and notify MD.
- Give: diphenhydramine 1 mg/kg/dose (max 50 mg) IVP x1, dexamethasone 0.1 mg/kg/dose (max 8 mg) IVP x1
- If hypotensive, give 0.9% NaCl 20 mL/kg IV bolus (max 500 mL) x1

FOR ANAPHYLAXIS: Stop infusion
- Give epi (1:1000) 0.01 mg/kg (max 0.3 mL) IM q15 min prn x2
- Call 911 and notify MD

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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