

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: intake@12stonehealth.com



TZIELD ORDER FORM

Date: _____	ICD-10 Code: _____	Therapy Status
Patient Name: _____	Allergies: _____	<input type="checkbox"/> New Start
Date of Birth: _____	Weight: _____ lbs OR _____ kg	<input type="checkbox"/> Continuing Therapy: Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____	Provider Fax: _____
Provider NPI: _____	Provider Address: _____
Provider Phone: _____	

MEDICATION ORDER

Tzield	Intravenous infusion over a minimum of 30min once daily for 14 consecutive days as follows: ✓ Day 1: 65mcg/m ² ✓ Day 2: 125mcg/m ² ✓ Day 3: 250mcg/m ² ✓ Day 4: 500mcg/m ² ✓ Day 5 through day 14: 1,030mcg/m ² <input type="checkbox"/> By checking this box, I confirm stage 2 Type 1 Diabetes, by at least two positive pancreatic islet autoantibodies	Refills for one year from date of signature unless indicated below. _____ Refills	<p>Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</p> <p>✓ CBC w/ Diff and LFT's</p>
---------------	---	--	---

PRE-MEDICATIONS

<p><u>Premed for first 5 treatments:</u></p> <input type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: 10mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <p style="text-align: center;">OR</p> <input type="checkbox"/> Adjust Acetaminophen and Diphenhydramine for pediatric weight based dosing.	<p><u>Oral</u></p> <input type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: 10mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____	<p><u>IV</u></p> <input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Methylprednisolone: 125mg <input type="checkbox"/> Hydrocortisone: 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____
---	---	--

LAB ORDERS (please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

Surveillance lab ordering and monitoring is the responsibility of the prescriber	(Please fax this signed order form, along with the following documents to 800-223-4063) <ul style="list-style-type: none"> • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work
--	---

By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written: _____	Substitution Allowed: _____
Prescriber Name _____ Date _____	Prescriber Name _____ Date _____