Provention Bio
COMPASS™ | provention bio
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PATIENT START FORM

TZIELD® (teplizumab-mzwv) Injection 2 mg/2 mL

Please sign, date, and fax the form to 908-425-4840
Form must be submitted by prescriber's office only

For more information about **Provention Bio COMPASS**, call 1-844-778-2246 Monday through Friday, 8 AM-8 PM ET.

Provention Bio COMPASS aims to provide confirmation of receipt within 24 hours of receiving this enrollment. If you do not receive confirmation of receipt, please call Provention Bio COMPASS.

Indicates required field.

1 PATIENT INFORMATION

❑ ***I certify that as the prescriber, I have engaged in a comprehensive discussion about the therapy with the patient, and the patient has given their consent to begin treatment.**

***Patient First Name:** _____ ***Patient Last Name:** _____ ***Sex Assigned at Birth:** ❑ Male ❑ Female ***Date of Birth:** ____/____/_____

***Patient Address:** _____ ***City:** _____ ***State:** _____ ***ZIP:** _____

***Primary Phone #** (leave blank if patient is under 18 years old): _____ Email (leave blank if patient is under 18 years old): _____

Preferred Form of Communication: ❑ Phone ❑ Text ❑ Email ❑ Do not contact patient

Best Time to Contact: ❑ Morning ❑ Afternoon ❑ Night

Preferred Language: ❑ English ❑ Spanish ❑ Other _____

Guardian/Caregiver information is required for patients under 18 years old (leave blank if patient is over 18 years old):

***Guardian/Caregiver Name:** _____ ***Relationship to Patient:** _____

***Guardian/Caregiver Primary Phone #:** _____ Email: _____

Secondary Caregiver Name: _____ Relationship to Patient: _____

Secondary Caregiver Primary Phone #: _____ Email: _____

2 INSURANCE INFORMATION

***Primary Insurance:** _____

❑ Patient has no insurance (proceed to Section 3)

***Insurance Provider:** _____ ***Phone #:** _____ ***Policy ID #:** _____ ***Group #:** _____

***Policy Holder Name:** _____ ***Policy Holder Date of Birth:** ____/____/_____ ***Policy Holder Relationship to Patient:** _____

***RxBIN #:** _____ ***PCN #:** _____

Secondary Insurance: _____

Insurance Provider: _____ Phone #: _____ Policy ID #: _____ Group #: _____

Policy Holder Name: _____ Policy Holder Date of Birth: ____/____/_____ Policy Holder Relationship to Patient: _____

Please attach a copy of both sides of the patient's medical and pharmacy insurance card(s) via fax with this prescription form.
***Please note:** Product is available through limited specialty pharmacies. Actual dispensing method may be specified by the patient's insurance.*

Please Select Acquisition Method:

Specialty Distributor: ❑ Cardinal Specialty Distribution

Specialty Pharmacy: ❑ Orsini® ❑ Amber™ and its affiliated entity Hy-Vee® Pharmacy Solutions ❑ No preference ❑ Unsure

3 PRESCRIBER INFORMATION

***Clinic Name:** _____ ***First Name:** _____ ***Last Name:** _____

***Prescriber NPI:** _____ ***Prescriber Tax ID:** _____ ***Address:** _____

***City:** _____ ***State:** _____ ***ZIP:** _____ ***Office Contact Name:** _____

***Office Contact Phone #:** _____ ***Fax #:** _____ ***Office Contact Email:** _____

4 INFUSION SITE OF CARE INFORMATION

❑ I have discussed infusion site of care preferences with patient. ❑ I have not discussed infusion site of care preferences with patient.
❑ I would like assistance from Provention Bio COMPASS to advise on an infusion site.
❑ I will provide infusion site information. Patient will be infused at:
- ❑ Prescriber's office (SECTION 3)
- ❑ At home with a nurse (same address as SECTION 1; if different, list on next page)
- ❑ Infusion facility (please list on next page)
- ❑ Both facility and home. Please indicate the number of doses to be infused at each location and list the infusion site below: _____ days to be infused at facility _____ days to be infused at home

Before prescribing TZIELD, please read the accompanying Prescribing Information, including Medication Guide.

*Indicates required field.

*Patient Last Name: _____ *Patient First Name: _____ *Date of Birth: ____/____/_____

Infusion Site (if unknown, Provention Bio COMPASS can support with infusion site identification/options)

Infusion Site Name: _____ Infusion Site NPI: _____ Tax ID #: _____

Address: _____ City: _____ State: _____ ZIP: _____

Infusion Center Contact Name: _____ Infusion Center Contact Phone #: _____ Fax #: _____

5 CLINICAL DIAGNOSIS

*Primary Diagnosis ICD-10 Code: ❑ E10.9 ❑ E10.8 ❑ Other (Include ICD-10): _____

*Please indicate which tests have been conducted to confirm patient's diagnosis (please attach clinical documentation of these test results):

*Confirmation of dysglycemia without overt hyperglycemia:

❑ Oral Glucose Tolerance Test (OGTT) (CPT® Code: 82951)

❑ Fasting Plasma Glucose (FPG) (CPT® Code: 82947)

❑ A1C (CPT® Code: 83036)

*Glucose/A1C level: _____

*Date test completed: _____

*Confirmation of at least 2 pancreatic islet cell autoantibodies (select positive autoantibodies below):

❑ Insulin autoantibody (IAA) (CPT® Code: 86337)

❑ Glutamic acid decarboxylase 65 (GAD) (CPT® Code: 86341)

❑ Insulinoma-associated antigen 2 autoantibody (IA-2A) (CPT® Code: 86341)

❑ Islet cell autoantibody (ICA) (CPT® Code: 86341)

❑ Zinc transporter 8 autoantibody (ZnT8A) (CPT® Code: 86341)

*Date test completed: _____

❑ *I certify that the patient's clinical history and associated diagnosis do not suggest Stage 3 type 1 diabetes (clinical symptoms and overt hyperglycemia).

❑ *I certify that the patient's clinical history and associated diagnosis do not suggest type 2 diabetes.

Please call Provention Bio COMPASS at 1-844-778-2246 Monday through Friday, 8 AM-8 PM ET, if you have questions about the required tests.

Patient Allergies: _____

Prior/Current Medications: _____

6 TZIELD® (teplizumab-mzwv) INJECTION 2 mg/2 mL PRESCRIPTION INFORMATION

Infuse according to the body surface area-based dosing regimen in the Prescribing Information for TZIELD.

*Patient Height: *Patient Weight: *Body Surface Area (BSA): m^2 *Date Measured:

Calculate using the Mostellar formula

*Quantity to Dispense:	BSA:
❑ **14** TZIELD 2 mg/2 mL, single-dose vials	≤ 1.94 m^2
❑ **24** TZIELD 2 mg/2 mL, single-dose vials	> 1.94 m^2

Refills: No refills

By signing below, I certify that the above therapy is medically necessary and that I will supervise the patient's treatment accordingly.

SIGN

_____ _____ OR _____ _____

Prescriber Signature—Dispense as Written (No Stamp Allowed) *Date* *Prescriber Signature—Generic Substitution Allowed (No Stamp Allowed)* *Date*

By signing above, I certify that (1) the information contained in this application is current, complete, and accurate to the best of my knowledge; (2) the above therapy is medically necessary and in the best interest of the patient identified above and that I will supervise the patient's treatment accordingly; (3) I have obtained any consent required under federal and state law for the release and use of the patient's personal health information including diagnosis, treatment, medical, and insurance information contained on this form to Provention Bio and its agents, service providers, and affiliates, including commercial and field-based teams, for purposes of benefits verification and coordination of dispensing therapy, or to otherwise assist the patient to initiate or continue the prescribed therapy and/or to evaluate the patient's eligibility for Provention Bio COMPASS or other programs for TZIELD; and (4) I will not seek payment from any payer, patient, or other source for free product provided directly to the patient. I have obtained patient's permission to enroll them in Provention Bio COMPASS and for them to be contacted by Provention Bio in connection with this application.

I understand that I am under no obligation to prescribe any Provention Bio therapies or to participate in Provention Bio COMPASS, and that I have not received, nor will I receive, any benefit from Provention Bio for prescribing a Provention Bio therapy. I certify that I am a legal resident of the United States (and US territories).

I authorize Provention Bio and its agents to convey the above prescription by any means allowed under applicable law to the dispensing pharmacy.

Before prescribing TZIELD, please read the accompanying Prescribing Information, including Medication Guide.

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