Local Infusion

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# GAZYVA (OBINUTUZUMAB) ORDER FORM

## PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ Patient has known difficult venous access. Comments:_____

❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

## DIAGNOSIS (Provider must specify)

❑ For the treatment of adult patients with active lupus nephritis (LN) who are receiving standard therapy,
ICD 10: M32.14._____

## PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

**Prerequisites to treatment –** ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

## PRE-MEDICATION (Recommendations per PI are selected, these will be given to the patient unless otherwise specified.)

☑ Acetaminophen (Tylenol) 500 mg PO

☑ Benadryl 25mg PO

❑ Famotidine 20 mg IV

❑ Cetirizine (Zyrtec) 10 mg PO

☑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Other: _____ Dose: _____ Route: _____

## MEDICATION

| MEDICATION | DOSE / FREQUENCY | ROUTE |
|---|---|---|
| Gazyva | Active lupus nephritis is 1,000 mg at the initial infusion, on Week 2, 24, 26, and every 6 months thereafter. | IV |

## LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

**FAX NUMBERS:**

❑ CT: 203.433.0621
❑ FL: 904.877.9270
❑ MA: 413.296.8482
❑ MD: 240.224.8607
❑ ME: 207.407.7272
❑ NC: 919.984.8698
❑ NH: 603.217.5371
❑ NJ: 201.581.4521
❑ NY: 631.250.6020
❑ OH: 937.871.4594
❑ PA: 610.273.5998
❑ SC: 864.973.6279
❑ VA: 703.202.0499