MIC | METRO INFUSION CENTER

Name: _____
DOB:_____
Diagnosis/Code: _____/_____
Cancer Stage:_____

Obinutuzumab (GAZYVA®)

Flat dosing no BSA/Mg/KG dosing

BSA: N/A

Patient Clearance: **Attach treatment Consent Form ☐**

Patient will be seen by Oncology Provider prior to every _____ cycle and cleared for treatment (Metro staff will also review symptoms prior to each treatment)

Acceptable time frame from labs to day of infusion (Metro centers are not all open every day) 3 days/_____days

Laboratory or Other tests related to treatment that should be completed by referring office prior to clearance for Infusion:

Will be done at referring office (Name and phone# of who to expect labs from):_____

☐ CMP with each treatment ☐ CBC with each treatment **(NEED Hepatitis panel prior- send results)**

Dosing Guidelines/Parameters: ***Provider must select parameters that will trigger a call from the Infusion staff***

☐ Hold and call provider for ANC: _____ /Platelet:_____

☐ Other hold parameters _____

☐ No hold parameters

Hydration Orders:

☐ Not required Other_____

Premedication and Antiemetic orders:

DRUG	DOSE	ROUTE	FREQUENCY, DAYS TO BE GIVEN
Steroid (choose 1 for first dose and if pt had prior reaction): ☐ Methylprednisolone	80mg	IV	1 hour prior to first dose of Obinutuzumab (Gazyva) ☐ Patient had prior reaction, use steroid prior to all infusions
☐ Dexamethasone	20mg		
Acetaminophen	☐ 650mg ☐ 1000mg	PO	30 minutes prior to all doses of Obinutuzumab (Gazyva)
Diphenhydramine	50mg	☐PO ☐IV	30 minutes prior to all doses of Obinutuzumab (Gazyva)

Treatment orders:

DRUG	DOSE CALCULATION Flat dosing	DOSE	ROUTE	RATE	FREQUENCY, DATES TO BE GIVEN
☐ Obinutuzumab (Gazyva)	Flat Dosing	100mg	IVPB	Infuse at 25mg/hr over 4 hours	Cycle 1 Day 1 (for CLL patients)
☐ Obinutuzumab (Gazyva)	Flat Dosing	900mg	IVPB	50 mg/hr. The rate of the infusion can be escalated in increments of 50 mg/hr every 30 minutes to a maximum rate of 400 mg/hr.*	Cycle 1; Day 2 (CLL patients)
☐ Obinutuzumab (Gazyva)	Flat Dosing	1000mg	IVPB	50 mg/hr. The rate of the infusion can be escalated in increments of 50 mg/hr every 30 minutes to a maximum rate of 400 mg/hr.*	☐ Days 8; 15 (after loading) ☐ Days 1; 8; 15 cycle 1 ☐ Every 28 days ☐ Every 2 months
☐ Obinutuzumab (Gazyva)					

Date of intended first treatment at Metro Infusion Center: _____

Subsequent treatment may be given +/- 2 days or as otherwise specified _____ *And rate can be increased to 100mg every 30 min if no IRR

This order is good for 1 year from the date ordered

Other:

Oral cancer treatment patient is taking: _____

Call referring provider for:

Date: Referring Provider: _____ _____ Phone# _____

SIGNATURE REQUIRED **PRINTED NAME REQUIRED**

All information in this order is strictly confidential and will become part of the patient's medical record. Contact us with questions at (877)448-3627. Send completed form and all documentation to confidential email: MICreferral@metroinfusioncenter.com or fax to (866)507-1164.

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