

Gazyva (obinutuzumab)

REFERRAL STATUS: New Referral Dose or Frequency Change Order Renewal

Infusion Office Preference: _____

PATIENT INFORMATION	
Date:	Patient Name: DOB:
<input type="checkbox"/> NKDA Allergies:	Weight (lbs / kg): Height:
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy - Last Treatment Date:	Next Due Date:
PROVIDER INFORMATION	
Office Contact Name:	Office Email:
Prescribing Providers Name:	Provider NPI:
Office Address:	City: State: Zip:
Office Phone Number:	Office Fax Number:
DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Lupus nephritis (active)	ICD 10 Code: M32.14
<input type="checkbox"/> Other: _____	<input type="checkbox"/> ICD 10 Code:
REQUIRED DOCUMENTATION/Testing	
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance info <input type="checkbox"/> Clinical/Progress notes supporting primary dx	<input type="checkbox"/> Hepatitis B Test Results: Hep B surface Antigen & Hep B Core TOTAL Antibody
List Tried & Failed Therapies 1)	2)
PREMEDICATION ORDERS	
<i>Manufacture recommends premedicate patients with glucocorticoid, acetaminophen, and anti-histamine</i>	
<input type="checkbox"/> acetaminophen (Tylenol) PO <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg	
<input type="checkbox"/> diphenhydramine (Benadryl) PO / IV <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg (if route is not circled PO will be administered)	
<input type="checkbox"/> methylprednisolone (Solu-Medrol) IV <input type="checkbox"/> 60mg <input type="checkbox"/> 100mg <input type="checkbox"/> 125mg <input type="checkbox"/> ____ mg	
<input type="checkbox"/> Other:	
MEDICATION ORDERS	
Initial Dosing	<input type="checkbox"/> 1,000 mg IV at weeks 0, 2, 24, 26 then every 6 months thereafter
Maintenance Dosing	<input type="checkbox"/> 1,000 mg IV every 6 months
Refills*: <input type="checkbox"/> None <input type="checkbox"/> X6 months <input type="checkbox"/> X1 year <input type="checkbox"/> Other: _____	
*(if not indicated order will expire one year from date signed)	

SPECIAL INSTRUCTIONS

*Referring physician is responsible for clinical monitoring of patient for neutropenia, thrombocytopenia and progressive multifocal leukoencephalopathy (PLL).

Fax referral to 866-507-1164 or email to bionurses@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.