

Gazyva (obinutuzumab)



METRO INFUSION CENTER

REFERRAL STATUS: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: _____

PATIENT INFORMATION	
Date:	Patient Name: DOB:
☐ NKDA Allergies:	Weight (lbs / kg): Height:
Patient Status: ☐ New to Therapy ☐ 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	
☐ Lupus nephritis (active)	ICD 10 Code: M32.14
☐ Other: _____	☐ ICD 10 Code:
REQUIRED DOCUMENTATION/Testing	
☐ This signed order form by the provider ☐ Patient demographics AND insurance info ☐ Clinical/Progress notes supporting primary dx	☐ 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> ☐ acetaminophen (Tylenol) PO ☐ 500mg ☐ 650mg ☐ 1000mg ☐ diphenhydramine (Benadryl) PO / IV ☐ 25mg ☐ 50mg (if route is not circled PO will be administered) ☐ methylprednisolone (Solu-Medrol) IV ☐ 60mg ☐ 100mg ☐ 125mg ☐ ____ mg ☐ Other:	
MEDICATION ORDERS	
Initial Dosing	☐ 1,000 mg IV at weeks 0, 2, 24, 26 then every 6 months thereafter
Maintenance Dosing	☐ 1,000 mg IV every 6 months
Refills*: ☐ None ☐ X6 months ☐ X1 year ☐ Other: _____ <i>*(if not indicated order will expire one year from date signed)</i>	

SPECIAL INSTRUCTIONS

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

Provider Name (Print)

Physician Signature:

Date:

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.

Created 8/28/26