

GAZYVA

Please include the following to expedite the order:
Patient Demographics, Insurance Information, Labs

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ DOB: _____ Gender: ☐ M ☐ F ☐ Other _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

PRESCRIBER

Name: _____ DEA: _____ NPI: _____ State License: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

CLINICAL

Diagnosis: ☐ C91.10 (Chronic Lymphocytic leukemia) ☐ M32.14 (Lupus Nephritis) ☐ Other: _____

Allergies: _____ Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in

CBC Completed: ☐ Yes ☐ No CMP/LFTs Completed: ☐ Yes ☐ No

HBV: ☐ Positive ☐ Negative If Positive, Treated: ☐ Yes ☐ No

TREATMENT

GAZYVA (obinutuzumab)

Route: Intravenous infusion

Dose: ☐ 1000mg

Frequency:

☐ Dose 1-4: 1000mg at week 0, 2, 24, and 26

☐ Dose 5+: 1000mg once every 6 months

Premedication Protocol:

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Acetaminophen: ☐ 650mg ☐ 1000mg PO

☐ Methylprednisolone: ☐ 80mg ☐ 125mg IV

☐ Other: _____

Sig: _____

It is recommended to premedicate with an IV glucocorticoid (i.e. 80mg methylprednisolone), 650 to 1000mg acetaminophen, and an antihistamine (i.e. diphenhydramine 50mg) 30 to 60 min before infusions 1-5 and an antipyretic and antihistamine before infusions 6 and beyond

☒ Center will use anaphylactic and hypersensitivity protocol established by Restore Health

Special Instructions: _____

Quantity: _____ Refills: _____

Provider Signature: _____

Date: _____

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