RESTORE HEALTH
INFUSION AND WELLNESS

GAZYVA

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

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

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

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

PRESCRIBER INFORMATION

Prescriber Name: _____ **DEA:** _____ **NPI:** _____ **State License:** _____

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

Phone: _____ **Fax:** _____

CLINICAL INFORMATION

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 INFORMATION

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

Quantity: _____ **Refills:** _____

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

Special Instructions: _____

Provider Name: _____ Provider Signature: _____ Date: _____

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