

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:

Patient Demographics, Insurance Information, All Clinical Documentation Supporting the Diagnosis, Including Any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing, Recent Labs Including Hep B Results

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code (required): M32.14 ICD Description: _____

Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

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

NURSING

- Deliver patient care in accordance with Infusion for Health clinical procedures and the medication's prescribing information (PI), including management of hypersensitivity reactions
- Hep B (HBsAb and anti-HBc) Test Results (list & attach clinicals)

PRE-MEDICATION ORDERS

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.

- Acetaminophen 650mg / 1000mg PO
 - Diphenhydramine 25mg / 50mg PO IV
 - Methylprednisolone 80mg / 125mg IV
 - Other: _____
- Dose: _____ Route: _____

SPECIAL INSTRUCTIONS:

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- Other _____ Frequency: _____
- Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

THERAPY ADMINISTRATION

- Gazyva Intravenous Infusion
- Doses 1-4:
- 1000mg at Week 0 and Week 2
 - 1000mg at Week 24 and Week 26
- Doses 5 and thereafter:
- 1000mg every 6 months
 - Refills: Zero / for 12 months / _____
(if not indicated, order will expire one year from date signed)
- To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.*

Provider Name (Print) _____ Provider Signature _____ Date _____

- Please check this box if you DO NOT authorize Infusion for Health to complete a Peer-to-Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.