Gazyva
(Obinutuzumab)

INFUSION FOR HEALTH

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 (HBsAg 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.***