City Infusions
WWW.CITYINFUSIONS.COM
Phone: 703-375-9577 Fax: 703-839-9750

GAZYVA (OBINUTUZUMAB) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____ kg

Allergies: _____

❑ Comments: _____

☐ New Start Therapy | ☐ Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

☑ Active Lupus Nephritis (LN) in adults receiving standard therapy, ICD 10: M32.14. _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Hepatitis B screening (HBsAg & anti-HBc)

PRE-MEDICATION

These will be administered 30–60 minutes prior to Gazyva infusion unless otherwise specified

☑ Methylprednisolone (Solu-Medrol) 80mg IV ☑ Benadryl 50 mg PO ☑ Acetaminophen (Tylenol) 650 mg PO

☐ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Gazyva	1,000 mg	IV	Weeks 0, 2, 24, 26 and then every 6 months thereafter

OTHER NOTES

Order valid for 1 year from date of signature unless otherwise specified here: _____