INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Gazyva *obinutuzumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Adults with active lupus nephritis (LN) who are receiving standard therapy, ICD 10: M32.14 _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ HBsAg (Hepatitis B surface antigen) & Anti-HBc (Hepatitis B core antibody, total or IgG)
☐ Demographics
☐ Labs and tests supporting diagnosis
☐ Office/progress notes

PRE-MEDICATION

Recommendations per PI are pre-selected; these will be given unless otherwise specified.

☑ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☑ Methylprednisolone (Solu-Medrol) 125 mg IVP
☑ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE / FREQUENCY	ROUTE
Gazyva	Active lupus nephritis: 1,000 mg at the initial infusion, then at weeks 2, 24, 26, and every 6 months thereafter	IV

LABS / SPECIAL INSTRUCTIONS

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