GAZYVA (obinutuzumab)

☐ New Prescription/Referral
☐ Prescription Refill

 # Of Refills:

Rx:

Patient Name:

Patient Weight: kg

DOB:

Gazyva: (obinutuzumab)

☐ Initial Dose: 1,000 mg IV at weeks 0, 2, 24, 26, then every 6 months

☐ Maintenance Dose: 1,000 mg IV every 6 month

☐ Others: _____

_____

Pre-Medication:

☐ Solumedrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Others: _____

☐ Tylenol _____ mg PO
☐ 650 mg ☐ 975 mg

☐ Benadryl _____ mg PO
☐ 25 mg ☐ IV
☐ 50 mg ☐ PO

ANA Kit Protocol:

☐ OK to use

Dx:

Diagnosis: ☐ Lupus nephritis (active) (M32.14)

☐ Other: _____

☐ ICD-10: _____

Physician Signature | **NPI #:** | **DATE:(Valid for 1 year)**

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name: | **Clinic:**

Phone: **Fax:** **Email:** **Other:**

Office Mailing Address:

Please include the following

☐ Patient demographics ☐ Insurance attached ☐ Diagnosis(supporting) ☐ History & Physical
☐ Lab Results ☐ Clinical progress notes ☐ Medication list ☐ Other Test Results
☐ Hep B Surface Antigen & Hep B Core Total Antibody

We can do patient teaching for IV/IM/SQ injections if needed. One time or multiple visits. If insurance allows we can also administer SQ/IM shot.