



PATIENT INFORMATION

*Patient Insurance & ID (front and back) are needed

Name: DOB: Weight: **kg**

PHYSICIAN INFORMATION

Prescriber Name: Phone: Fax:

Office Contact: *Email (for the referral update):

Clinic: Address:

NPI:

Patient's PCP Name: Phone: Fax:

Clinic: Address:

NPI:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Gazyva: Initial Dose: 1,000 mg IV at weeks 0, 2, 24, 26, then every 6 months
(obinutuzumab)

Maintenance Dose: 1,000 mg IV every 6 month

Others: _____

Pre-Medication:

Solumedrol 125mg IVP	Tylenol _____ mg PO	Benadryl _____ mg PO
Solu-Cortef 100mg IVP	650 mg 975 mg 1000mg	25 mg IV
Others: _____		50 mg PO

ANA Kit Protocol:

OK to use

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

Other: _____

ICD-10: _____

PRESCRIBER SIGNATURE: x

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.

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			