

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____
 Address: _____ City/ST/Zip: _____
 Allergies: _____ NKDA Weight: _____ lbs kg Height: _____ in cm
Patient Status: New to Therapy Dose or Frequency Change Order Renewal

INSURANCE INFORMATION: Please attach copy of insurance card (front and back).

DIAGNOSIS*

*ICD 10 Code Glomerular disease in systemic lupus erythematosus, M32.14
 Required Other: _____, ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE, DIRECTIONS and DURATION
Gazyva® (obinutuzumab)	<input type="checkbox"/> INITIAL: Infuse 1000 mg IV at Weeks 0, 2, 24, and 26, then every 6 months x 1 year <input type="checkbox"/> MAINTENANCE: Infuse 1000 mg IV every 6 months x 1 year Administration: <ul style="list-style-type: none"> • Dose #1 Only: Infuse IV over approximately 4.25 hours. Start infusion at rate of 50 mg/hr x 30 minutes, then may increase rate in 50 mg/hr increments every 30 minutes to maximum rate of 400 mg/hr. • Dose #2 and thereafter: <ul style="list-style-type: none"> ▪ Standard Rate: Infuse IV over approximately 3.25 hours. Start infusion at rate of 100 mg/hr x 30 minutes, then may increase rate in 100 mg/hr increments every 30 minutes to maximum rate of 400 mg/hr. ▪ 90-Minute Rate (only if no Grade 3 or higher IRR during previous infusion): Infuse IV over 90 minutes. Start infusion rate at 100 mg/hr x 30 minutes, then increase to 900 mg/hr for approximately 60 minutes.

Has patient received therapy above from another facility? If yes, Facility Name: _____
 Yes No Date of Last Treatment: _____ Date of Next Treatment: _____

PRE-MEDICATION ORDERS

- Acetaminophen 650 – 1000 mg PO 30-60 minutes prior to infusion
- Diphenhydramine 50mg PO 30-60 minutes prior to infusion
- Methylprednisolone 80mg IV 30-60 minutes prior to infusion
 May D/C after 5th dose if no IRR observed
- Other: _____

LAB ORDERS

- Labs to be drawn by:** Infusion Center Referring Physician
 No labs ordered at this time
 Blood glucose q _____ CBC with diff/platelet q _____
 CMP q _____ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____
 Physician Name: _____ NPI: _____ TIN: _____ Specialty: _____
 Address: _____ City/ST/Zip: _____
 Contact Person: _____ Phone #: _____ Fax #: _____
 Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

- Gazyva® is being used for the treatment of active lupus nephritis.
- Class III-V lupus nephritis is confirmed by kidney biopsy.
- Gazyva® will be used in combination with a standard of care therapy regimen for active systemic lupus erythematosus (e.g., antimalarials, corticosteroids, or immunosuppressants).

LAB AND TEST RESULTS (required)

- Kidney biopsy test result
- eGFR lab result