GAZYVA®
(obinutuzumab)

Advanced Infusion Care Centers®

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

PRIMARY DIAGNOSIS

☐ ICD10 Code: _____

PRESCRIPTION

GAZYVA (obinutuzumab)

☐ Induction Dose: GAZYVA (obinutuzumab) 1000 mg IV at weeks 0, 2, 24, and 26

☐ Maintenance Dose: GAZYVA (obinutuzumab) 1000 mg IV every 6 months

☐ Other: _____

Has patient received any doses of this medication in the past? ☐ Yes ☐ No

☑ Refill x 12 months unless otherwise noted: _____

REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Medication List
- Most recent labs
- Tried and Failed therapies (including duration)
- Negative Hep B screening (Hepatitis B antigen)

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol.
(See aiscaregroup.com for detailed policy)

☐ Other: Please fax other adverse reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

Per infusion center protocol:
Methylprednisolone sodium succinate 80 mg IV given 30-60 minutes prior to infusion.
Diphenhydramine 50 mg PO 30-60 minutes prior to infusion.
Acetaminophen 650 mg-1000 mg PO 30-60 minutes prior to infusion.

☐ Other: _____

LINE CARE ORDERS

Start PIV/Access CVC

Flush device per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*

☐ Other Flush Orders: Please fax other line care orders if checking this box

LAB ORDERS—PLEASE INCLUDE FREQUENCY

☐ Please list any labs to be drawn by the infusion clinic: _____

☑ CBC w/diff, CMP prior to week 2, 24, 26, then every 6 months thereafter

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Fax: 855.217.1930 | Phone: 800.482.8466 | Email: AICCreferrals@aiscaregroup.com | Visit: aiscaregroup.com/patient-referral-forms/

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