REVITALIZE
INFUSION CENTER

Gazyva®

Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis:

☐ Glomerular disease in systemic lupus erythematosus (SLE) ICD-10 Code: M32.14

☐ Other_____ ICD-10 Code_____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
  - Documentation of treatments trialed/failed previously
- Relevant labs and tests
- Active Medication List
  - ☐ Patient to hold antihypertensive medications _____ days prior to infusion
- Required Information:
  - Hepatitis B Screening Results (HBsAG and Anti-HBc)
  - Clarification regarding antihypertensive regimens if applicable due to risk of hypotension

Height: _____

Weight: _____

Gazyva (obinutuzumab) Order:

☐ **Initiation Dosing:**

Administer 1,000 mg intravenously on Week 0, Week 2, Week 24 and Week 26 to provide four (4) doses

☐ **Maintenance Dosing:**

Administer 1,000 mg intravenously every six (6) months for 12 months to provide two (2) doses

Pre-Medication Orders: 30 minutes prior to infusion

☐ Acetaminophen 650 mg PO ☐ Diphenhydramine 50 mg PO

☐ Methylprednisolone 125 mg IV ☐ Other: _____

Lab Orders:_____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

Please fax the completed order form and all other requested information to: 601-714-1569

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus