Obinutuzumab (GAZYVA)

Provider Order Form rev. 7/13/2026

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

☐ M32.14: Lupus Nephritis

Other: Description:

THERAPY ADMINISTRATION *(Select one)*

☐ Initial and then Maintenance Dosing: 1,000 mg IV at week 0, 2, 24, 26, then every 6 months

☐ Maintenance Dosing Only: 1,000 mg IV every 6 months

PRE-MEDICATION ORDERS

(Per PI required premeds will be given unless otherwise specified)

All premedication must be given 30-60 minutes prior to infusion

☑ Tylenol 650 mg PO/☐ Other antipyretic:_____

☑ Benadryl 50 mg PO/☐ Other antihistamine:_____

☑ Solumedrol 80 mg IV (only required for initial 5 doses)

☐ Solumedrol (6th dose on) ☐ 40mg/☐ 80mg/☐ 125mg IVP

☐ Loratadine 10mg PO

☐ Pepcid 20mg ☐ PO / ☐ IVP

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Signs/symptoms of infection, surgical procedures, recent live vaccines, neurological or mood changes.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications.

Required Labs: Include negative Hepatitis B, CBC w/diff platelets, renal function, CRP, ESR.

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.