Fairfield
1817 Black Rock Turnpike
Suite 204
Fairfield, CT 06824

Greenwich
469 W Putnam Ave
Ste 205,
Greenwich, CT 06830

ThrIVewell™ INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

GAZYVA Infusion orders

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ Discontinuation Order

PHYSICIAN INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Chronic Lymphocytic Leukemia (CLL)
- ☐ _____ Follicular Lymphoma (FL)
- ☐ _____ Lupus Nephritis (LN)
- ☐ _____ _____ *(other)*

PRE-MEDICATION

Standard Premeds (ALL PATIENTS)

- ☐ Acetaminophen 650 mg PO
- ☐ Acetaminophen 1,000 mg PO
- ☐ Diphenhydramine 50 mg PO
- ☐ Other:_____

Steroid Premedication

- ☐ Dexamethasone 20 mg IV
- ☐ OR Methylprednisolone 80 mg IV

PATIENT WEIGHT

_____ lbs.
_____ kg

DOSAGE:

CLL DOSING

- ☐ Cycle 1: ☐ Day 1: 100 mg
  - ☐ Day 2: 900 mg
  - ☐ Day 8: 1,000 mg
  - ☐ Day 15: 1,000 mg
- ☐ Cycles 2–6: 1,000 mg Day 1 every 28 days

FL DOSING

- ☐ Cycle 1: Day 1, 8, 15 → 1,000 mg
- ☐ Cycles 2–6 or 2–8: Day 1 → 1,000 mg
- ☐ Maintenance: 1,000 mg every 2 months (up to 2 years)

LUPUS NEPHRITIS DOSING

- ☐ 1,000 mg initial
- ☐ Week 2: 1,000 mg
- ☐ Week 24: 1,000 mg
- ☐ Week 26: 1,000 mg
- ☐ Then every 6 months

Route:
Intravenous (IV) infusion ONLY
Do NOT administer IV push or bolus

Total dosages_____/ Refills

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____