

Borough Park
1428 36th Street
Suite 107
Brooklyn, NY 11218

Forest Hills
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

E 56th & Park Midtown
120 East 56 Street
Suite 300
New York, NY 10022

NYC
E 70th St Upper East Side
225 E 70th Street
Suite 1E
New York, NY 10021



Tarrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523

Southampton
625 Hampton Road
Southampton, NY 11968

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

Sheepshead Bay
2546 East 17th Street
Fl. 1
Brooklyn, NY 11235

Long Island City
36-36 33rd
Suite 311
Long Island City, NY 11106

FIDI
30 Broad Street
Suite 401
New York, NY 10004

Central Park West
115 Central Park West
Suite 15
New York, NY 10023

Port Jefferson
12 Medical Drive
Suite B
Port Jefferson Station, NY 11776

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

Rockville Centre
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

Bronx
226 West 238th Street
Bronx, NY 10463

Massapequa
97 Grand Avenue
Massapequa, NY 11758

Gramercy
7 Gramercy Park West
Lower Level
New York, NY, 10003



Staten Island
27 New Dorp Lane
Staten Island, NY 10306

Holbrook
233 Union Avenue
Suite 207
Holbrook, NY 11741

New Hyde Park
1991 Marcus Ave
Suite 110
Lake Success, NY, 11042

Woodbury
7600 Jericho Tpke,
Lower Level, Suite C500
Woodbury NY 11797

GAZYVA Infusion orders

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> 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 _____