

Vermont
28 Park Ave
Suite #1A
Williston, VT 05495



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
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> 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: _____

<p>DIAGNOSIS <i>Please provide ICD-10 code</i></p> <p><input type="checkbox"/> _____ Chronic Lymphocytic Leukemia (CLL)</p> <p><input type="checkbox"/> _____ Follicular Lymphoma (FL)</p> <p><input type="checkbox"/> _____ Lupus Nephritis (LN)</p> <p><input type="checkbox"/> _____ _____ <i>(other)</i></p> <p>PRE-MEDICATION Standard Premeds (ALL PATIENTS)</p> <p><input type="checkbox"/> Acetaminophen 650 mg PO</p> <p><input type="checkbox"/> Acetaminophen 1,000 mg PO</p> <p><input type="checkbox"/> Diphenhydramine 50 mg PO</p> <p><input type="checkbox"/> Other: _____</p> <p>Steroid Premedication</p> <p><input type="checkbox"/> Dexamethasone 20 mg IV</p> <p><input type="checkbox"/> OR Methylprednisolone 80 mg IV</p>	<p>PATIENT WEIGHT</p> <p>_____ lbs.</p> <p>_____ kg</p> <p>DOSAGE: CLL DOSING</p> <p><input type="checkbox"/> Cycle 1: <input type="checkbox"/> Day 1: 100 mg</p> <p><input type="checkbox"/> Day 2: 900 mg</p> <p><input type="checkbox"/> Day 8: 1,000 mg</p> <p><input type="checkbox"/> Day 15: 1,000 mg</p> <p><input type="checkbox"/> Cycles 2-6: 1,000 mg Day 1 every 28 days</p> <p>FL DOSING</p> <p><input type="checkbox"/> Cycle 1: Day 1, 8, 15 → 1,000 mg</p> <p><input type="checkbox"/> Cycles 2-6 or 2-8: Day 1 → 1,000 mg</p> <p><input type="checkbox"/> Maintenance: 1,000 mg every 2 months (up to 2 years)</p> <p>LUPUS NEPHRITIS DOSING</p> <p><input type="checkbox"/> 1,000 mg initial</p> <p><input type="checkbox"/> Week 2: 1,000 mg</p> <p><input type="checkbox"/> Week 24: 1,000 mg</p> <p><input type="checkbox"/> Week 26: 1,000 mg</p> <p><input type="checkbox"/> Then every 6 months</p> <p>Route: Intravenous (IV) infusion ONLY Do NOT administer IV push or bolus</p> <p>Total dosages _____ / Refills _____</p>
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NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____