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**Obinutuzumab (Gazyva) Order Form**  
Epic Referral: REF115262

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **ICD-10 Diagnosis:** \_\_\_\_\_

**Rx:**

**Induction Dosing:**

Obinutuzumab 1000 mg IV at weeks 0, 2, 24 and 26

**Maintenance Dosing (beginning 6 months following last induction dose):**

Obinutuzumab 1000 mg IV once every 6 months

**Duration:**       6 months       1 year       Other: \_\_\_\_\_

**Pre-meds:** (given at each obinutuzumab infusion)

- Solumedrol 80 mg IV      or       Solumedrol \_\_\_\_\_ mg IV  
 Tylenol 1000 mg po      or       Tylenol 650 mg po  
 Benadryl \_\_\_\_\_ mg po      or       Benadryl \_\_\_\_\_ mg IV  
 Famotidine 20mg po  
 Other: \_\_\_\_\_

*Solumedrol 80 mg IV, Tylenol, and Benadryl 50 mg recommended per package insert.*

**Please send Hep B Panel results with order, we cannot infuse without Hep B Panel documentation.**

**Labs:**

- Draw CBC w/diff and CMP at each obinutuzumab infusion  
Other labs (include frequency): \_\_\_\_\_

\*\*Port/PICC care per protocol will be performed if applicable including heparin flush (500 units/5mL) and cathflo (2 mg) PRN for patients with a port\*\*

\*\*Urine hCG screening will be done prior to each treatment course where applicable

**Prescriber Printed Name:** \_\_\_\_\_

**Prescriber Full Address:** \_\_\_\_\_

**Office Phone Number:** \_\_\_\_\_ **Office Fax Number:** \_\_\_\_\_

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_