Ascension Rx

Obinutuzumab (Gazyva & Biosimilars) Injection Order Form - Lupus Nephritis Indication Only

Patient Name: _____ **Date of Birth:** _____

Patient Phone #: _____ **Date:** _____

Therapy Status: ☐ New Start ☐ Continuation ☐ Restart **Last Dose:**_____

Height (inches)	Weight (kg)	Allergies

Diagnosis

ICD-10 Code(s): _____ J Code(s): _____

Labs (Recommended to be done within 30 days of first dose)

- ☐ Labs to be reviewed or ordered by infusion center
  - ☑ Baseline
    - ☑ CMP
    - ☑ CBC with Differential
    - ☐ Quantitative Serum Immunoglobulins (IgG, IgM, IgA)
    - ☑ Hepatitis Screening prior to therapy (HBsAg, HepB core Ab total, HCV)
  - ☑ Maintenance (every _____)
    - ☑ CMP
    - ☑ CBC with Differential
- ☐ Labs reviewed by ordering provider, ok to proceed (Labs last done on _____)
- ☐ Other: _____

Provider Information

Live vaccines should not be given concurrently

Nursing Order

- ☑ Do not administer with an active infection (including active hepatitis B virus), including clinically important localized infection.
- ☑ Hold and notify provider if ANC < 500 or PLT < 25,000
- ☑ Pregnancy status: If uncertain, obtain HCG urine test for women 11 – 50 years prior to treatment.

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Pre-Medications

- [x] Acetaminophen 650 mg PO once
- [ ] Diphenhydramine 25 mg PO once
- [ ] Diphenhydramine 25 mg IV once
- [ ] Diphenhydramine 50 mg PO once
- [x] Diphenhydramine 50 mg IV once
- [ ] Famotidine 20 mg IV once
- [ ] Famotidine 20 mg PO once
- [ ] Dexamethasone 20 mg IV once
- [ ] Dexamethasone 20 mg PO once
- [ ] Methylprednisolone 125 mg IV once
- [x] Methylprednisolone 80 mg IV once (doses 1 to 5)
- [ ] Methylprednisolone 80 mg IV once (if needed for infusion reaction occurred during the immediately preceding infusion)
- [ ] Other: _____

IV Site Orders

- [x] Follow standard protocol for IV site management
- [x] In absence of standard protocol, follow the orders below:
  - [x] Sodium chloride 0.9% infusion 250 mL IV at 20 mL/hr PRN (carrier fluid/KVO)
  - [x] Start peripheral IV or access central line for infusion
  - [x] Sodium chloride 0.9% 10 mL flush to IV site as needed
  - [x] Heparin 50 units/5 mL flush to IV site as needed (central line only)
  - [x] Heparin 500 units/5 mL flush to IV site as needed (central line only)
  - [x] May use alteplase 2 mg intracatheter as needed for negative blood return of IV site

Medication Orders (select only one)

Initial Dose

- [ ] Obinutuzumab 1000 mg IV once on week 0, 2, 24, 26

Maintenance Infusions:

- [ ] Obinutuzumab 1000 mg IV once every 6 months

To be completed by Infusion Center staff only:

Biosimilar substitution/Product Dispensed: _____ J-Code: _____
Rounded Dose: _____ mg

Rationale for Substitution:

- [ ] Payer-mandated substitution
- [ ] Financial stewardship
- [ ] Patient access / hardship

Pharmacy may substitute a biosimilar based on insurance coverage.
Pharmacy may adjust diluent, volume, and infusion duration in accordance with local practice standards.

Administration Instructions

- **First Infusion:** Administer at a rate of 50 mg/hr. The rate of infusion can be escalated in 50 mg/hr increments every 30 minutes to a maximum of 400 mg/hr.

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- **Subsequent Infusions:** If no previous reaction, administer at a rate of 100 mg/hr. The rate of infusion can be escalated at a rate of 100 mg/hr every 30 minutes to a maximum of 400 mg/hr.

Emergency / Hypersensitivity Orders

- ☑ Notify provider for next steps once patient stabilized
- ☑ Follow standard orders for management of allergies and anaphylaxis reactions
- ☑ In absence of standard protocol, follow the orders below:
  - ☑ Nursing to stop infusion, maintain airway, place supine, elevate legs, O_2 2 L NC
  - ☑ Epinephrine 0.3 mg IM Once PRN anaphylaxis (first-line)
  - ☑ Diphenhydramine 25 mg IV q6h PRN itching/hives
  - ☑ Hydrocortisone 100 mg IV Once PRN hypersensitivity
  - ☑ Methylprednisolone 125 mg IV Once PRN hypersensitivity
  - ☑ Famotidine 20 mg IV Once PRN hives/itching
  - ☑ Albuterol inhaler 2 puffs Once PRN wheezing/SOB
  - ☑ Normal Saline 1000 mL IV bolus Once PRN hypotension

Infusion Center Staff

Please fax infusion records or discharge summary to: Fax Number _____

Provider Information

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider NPI: _____

Provider Address: _____ Phone: _____ Fax: _____

All orders are valid for 1 year from the ordered date unless otherwise indicated