Gazyva Infusion Order

LivWell INFUSIONS

Fax 888 511-7654 Phone 888 864 7341

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis: ◯ M32.14 Glomerular disease in systemic lupus erythematosus

◯ Other

ICD-10: _____

ALSO INCLUDE...

◯ Clinical/ Progress Notes
◯ Demographics Sheet
◯ Current Medications
◯ Labs
◯ Insurance Cards

GAZYVA ORDER

Gazyva Dose:

◯ New Patient: 1000mg intravenously week 0, 2, then repeat in 6 months

◯ Existing Patient: 1000mg intravenously every 6 months

◯ Other:

Date of last Gazyva Infusion: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____