TECENTRIQ HYBREZA (ATEZOLIZUMAB AND HYALURONIDASE-TQJS) PRESCRIBER ORDER FORM

Patient Name:			**Date of Birth:**	
Address:				
Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs. ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Tecentriq Hybreza (atezolizumab and hyaluronidse-tqjs) Prescription

Tecentriq Hybreza (atezolizumab and hyaluronidase-tqjs) Refill as directed x1 year

☐ Administer 15 mL (1,875 mg atezolizumab and 30,000 units hyaluronidase) **subcutaneously** into the thigh over approximately 7 minutes every 3 weeks.

Ancillary Orders

Anaphylaxis Orders

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SubQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Skilled Nursing to establish peripheral IV access as needed to manage anaphylaxis.

Pre-Medication Orders

☐ Acetaminophen 650 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for fever or mild discomfort.

☐ Diphenhydramine 25mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions.

☐ Other: _____

Lab Orders

☐ No labs ordered at this time.

☐ Other: _____

Skilled nurse to assess and administer as indicated above. Nurse will provide ongoing support as needed.
Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:		**NPI:**
City, State:	**Zip:**	**Office Contact:**

Fax completed form, insurance information, and clinical documentation to:

