

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 hyaluronidase-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:

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