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

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

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**
Allergies: ☐ NKDA OR (List):	

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: _____

Any labs ordered to be drawn by OCH nursing will be drawn during the appointment for infusion.
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.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

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: 713-983-4647

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