TECENTRIQ® (ATEZOLIZUMAB) 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: J9022**

Allergies: ☐ NKDA OR (List):

Tecentriq® (atezolizumab) Prescription

Tecentriq® (atezolizumab) Refill as directed x1 year

- ☐ 840 mg IV over 60 minutes every 2 weeks
- ☐ 1200 mg IV over 60 minutes every 3 weeks
- ☐ 1680 mg IV over 60 minutes every 4 weeks
- ☐ Other: _____

If patient tolerates first infusion, may infuse over 30 minutes

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.

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: _____

IV Flush Orders

- Peripheral: — 0.9% Sodium Chloride 3 to 5 mL pre-/post-use.
- PICC and Central Tunneled/ Non-Tunneled: — 0.9% Sodium Chloride 5 to 10 pre-/post-use, 5 mL pre-lab draw and 10 ml post-lab draw. Heparin (10 unit/mL) 5 mL or (100 unit/mL post-use. For maintenance, Heparin (10 unit/mL) 5 mL or (100 unit/mL)3 mL every 24 hr.
- Implanted Port: — 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr. if accessed or weekly to monthly if not accessed.
- Valved Catheters — 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. For maintenance, NS 5 to 10 ml at least weekly

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 via access device 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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