TECENTRIQ® (ATEZOLIZUMAB) PRESCRIBER ORDER FORM

	Fax completed form, insurance information, and clinical documentation to: 877-974-4845				
option care health	**Patient Name:**			**Date of Birth:**	
	Address:				
	Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs. ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code: J9022**

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 2 weeks
- ☐ Other: _____

If patient tolerates first infusion, may infuse over 30 minutes

Ancillary Orders

Anaphylaxis Orders

- ☒ Anaphylaxis Kit > Required per Option Care Health Policy - Please complete Anaphylaxis Physician Order (FR-PC-036) provided.

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:	NS 2 to 3 mL pre-/post-use.
☐	PICC and Central Tunneled/ Non-Tunneled:	NS 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:	NS 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:	NS 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: _____

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.

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:**

