

Tecentriq® (atezolizumab) Prescriber Order and Referral Form

Pharmacists with the Froedtert Pharmacy will be supporting this patient's infusion medication management.
Fax completed form, insurance information and clinical documentation to 414-260-7368.

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Height: _____ inches cm Weight: _____ lbs kg

Clinical Information

Primary Diagnosis Description: _____ ICD-10 Code: J9022 ICD-10 Codes: _____

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

- Treat per Froedtert Home and Specialty Infusion protocol.

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 Access and Flush Orders: RN to access and monitor venous infusion line as indicated below:

- Peripheral: Flush with 0.9% NS - 10 ml pre/post-use.
- Implanted Port or PICC: Flush with 0.9% NS - 10 ml pre/20 ml post-use and 10 ml pre/20 ml post-lab

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 _____ Time _____

Prescriber Name _____ Phone _____ Fax _____

Address _____ NPI _____

City, State, Zip _____ Office Contact _____



Original - Medical Records

Froedtert Home and Specialty Infusion
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