YEZTUGO® (lenacapavir) 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:

YEZTUGO Prescription

YEZTUGO® refill as directed x 1 year

☐ **Initiation Dose:** Day 1 = 600mg oral tablets + 927mg subcutaneous injection.
Day 2 = 600mg oral tablets x1 dose

☐ **Maintenance Dose:** Inject 927mg subcutaneously every 6 months from date of last injection +/- 2 weeks

NOTE: **Individuals must be tested for HIV-1 infection prior to initiating YEZTUGO and with each subsequent injection of YEZTUGO.**

Ancillary Orders

Anaphylaxis Kit

If this is a 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

☐ Yes ☐ No

- Epinephrine 0.3mg (>30kg), 0.15mg (15 to 30kg), or 0.01 mg/kg (30kg) or 1.25 mg/kg (< 30 kg) SUBQ or IM; repeat x 1 in 15 min PRN no improvement.
- Diphenhydramine 25mg (>30kg) 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

☐ Other: _____

Lab Orders

☐ No labs ordered at this time

☐ Other: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate 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: 1-331-551-7676

Not valid for use for patients residing in Arizona, New York, and Wisconsin

