

**YEZTUGO® (lenacapavir) PRESCRIBER ORDER FORM**

<b>Patient Name:</b>	<b>Date of Birth:</b>	<b>Gender:</b>
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<b>Address:</b>
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<b>Phone:</b>	<b>Height:</b>	<input type="checkbox"/> inches <input type="checkbox"/> cm	<b>Weight:</b>	<input type="checkbox"/> lbs <input type="checkbox"/> kg
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**Clinical Information**

<b>Primary Diagnosis Description:</b>	<b>ICD-10 Code:</b>
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**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 1<sup>st</sup> dose, would you like Option Care Health to provide an anaphylaxis kit with the 1<sup>st</sup> 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**

<b>Prescriber Name:</b>	<b>Phone:</b>	<b>Fax:</b>
<b>Address:</b>	<b>NPI:</b>	
<b>City, State:</b>	<b>Zip:</b>	<b>Office Contact:</b>

**Fax completed form, insurance information, and clinical documentation to: 1-331-551-7676**

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