

IBALIZUMAB-UIYK (TROGARZO®) PRESCRIBER ORDER FORM				
Patient Name:		Date of Birth:		Gender:
Address:				
Phone:		Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:
<input type="checkbox"/> lbs <input type="checkbox"/> kg				
Clinical Information				
Primary Diagnosis Description: Human immunodeficiency virus (HIV)			ICD-10 Code: B20	
Is this the first dose? <input type="checkbox"/> Yes – date of first dose: _____ <input type="checkbox"/> No – Date of last dose: _____				
Ibalizumab-uiyk (Trogarzo®) Prescription				
Ibalizumab-uiyk (Trogarzo®) 200 mg/1.33 mL vials refill as directed x 1 year Loading Dose: <input type="checkbox"/> Infuse 2000 mg IV infusion over 30 minutes x 1 dose. Repeat x 1 dose ASAP prn if patient misses a maintenance dose ≥ 3 days prior to resuming maintenance dose <input type="checkbox"/> Inject 2000 mg IV Push over at least 90 seconds x 1 dose. Repeat x 1 dose ASAP prn if patient misses a maintenance dose ≥ 3 days prior to resuming maintenance dose Maintenance Dose: <input type="checkbox"/> Infuse 800 mg IV over 15 minutes every 14 days <input type="checkbox"/> Inject 800 mg IV Push over at least 30 seconds every 14 days Flush IV administration set with 0.9% Sodium Chloride 30 to 50 mL after each infusion.				
Ancillary Orders				
Anaphylaxis Kit If this is a 1 st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1 st dose? <input type="checkbox"/> Yes <input type="checkbox"/> No <ul style="list-style-type: none"> 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. 				
Medication Orders <input type="checkbox"/> Other: _____				
IV Flush Orders				
<input type="checkbox"/> <u>Peripheral:</u>	0.9% Sodium Chloride 2 to 3 mL pre-/post-use.			
<input type="checkbox"/> <u>Peripheral-Midline:</u>	0.9% Sodium Chloride 3 to 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. Heparin (100 unit/mL) 3 mL post-use. For maintenance, flush with heparin (100 unit/mL) 3 mL every 24 hr.			
<input type="checkbox"/> <u>PICC and Central Tunneled/Non-Tunneled:</u>	0.9% Sodium Chloride 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. Heparin <input type="checkbox"/> (10 unit/mL) 5 mL <u>or</u> <input type="checkbox"/> (100 unit/mL) 3 mL post-use. For maintenance, flush with heparin (10 unit/mL) 5 mL or (100 unit/mL) 3 mL every 24 hr.			
<input type="checkbox"/> <u>Implanted Port:</u>	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.			
Lab Orders <input type="checkbox"/> No labs ordered at this time. <input type="checkbox"/> Other: _____				
Skilled nurse to assess and administer and/or teach self-administration, where appropriate, 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>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>				
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: (888) 410-2584				
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