IBALIZUMAB-UIYK (TROGARZO®) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
Address:		
Phone:	**Height:** ☐ inches ☐ cm	**Weight:** ☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description: Human immunodeficiency virus (HIV) **ICD-10 Code:** B20

Is this the first dose? ☐ Yes – date of first dose: ☐ 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:
- ☐ 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
- ☐ 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:
- ☐ Infuse 800 mg IV over 15 minutes every 14 days
- ☐ 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 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

☐ Yes ☐ No

- 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

☐ Other: _____

IV Flush Orders

☐ Peripheral:	0.9% Sodium Chloride 2 to 3 mL pre-/post-use.
☐ Peripheral-Midline:	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.
☐ PICC and Central Tunneled/Non-Tunneled:	0.9% Sodium Chloride 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. Heparin ☐ (10 unit/mL) 5 mL *or* ☐ (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.
☐ Implanted Port:	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

☐ No labs ordered at this time.

☐ 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 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: 888-410-2584

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