IBALIZUMAB-UIYK (TROGARZO®) PRESCRIBER ORDER FORM

Patient Name:			**Date of Birth:**	
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 next dose due:

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 over 30 minutes x 1 dose

☐ Repeat with 2000 mg IV over 30 minutes 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

Flush IV catheter 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.

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

