Sunlenca (lenacapavir) PRESCRIBER ORDER FORM

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

Sunlenca (lenacapavir) Prescription

Primary Diagnosis Description: **ICD-10 Code:**

Allergies: ☐ NKDA OR (List):

Initiation Dosing

☐ **2-Day Initiation**

Day 1: Oral 600mg x1 dose + Sub-Q 927mg x1 dose.

Day 2: Oral 600mg x1 dose

☐ **15-Day Initiation**

Day 1: Oral 600mg x1 dose.

Day 2: Oral 600mg x1 dose.

Day 8: Oral 300mg x1 dose.

Day 15: Sub-Q 927mg x1 dose

Maintenance Dosing

☐ Sub-Q 927mg every 6 months +/- 2 weeks from previous injection x1 year

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

Dosage:

- Epinephrine 0.3mg (>30kg), 0.15mg (15 to 30kg), or 0.01 mg/kg (<15kg) SUBQ or IM x 1; repeat x1 in 5 to 15 min PRN.
- 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:**	

