

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

<b>Patient Name:</b>		<b>Date of Birth:</b>		<b>Gender:</b>	
<b>Address:</b>					
<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
<b>Clinical Information</b>					
<b>Primary Diagnosis Description:</b>				<b>ICD-10 Code:</b>	
<b>YEZTUGO Prescription</b>					
<b>YEZTUGO® refill as directed x 1 year</b>					
<input type="checkbox"/> <b>Initiation Dose:</b> Day 1 = 600mg oral tablets + 927mg subcutaneous injection. Day 2 = 600mg oral tablets x1 dose					
<input type="checkbox"/> <b>Maintenance Dose:</b> Inject 927mg subcutaneously every 6 months from date of last injection +/- 2 weeks					
<b>NOTE:</b> Individuals must be tested for HIV-1 infection prior to initiating YEZTUGO and with each subsequent injection of YEZTUGO.					
<b>Ancillary Orders</b>					
<b>Anaphylaxis Kit</b>					
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?					
<input type="checkbox"/> Yes <input type="checkbox"/> No					
<ul style="list-style-type: none"><li>• Epinephrine 0.3mg (&gt;30kg), 0.15mg (15 to 30kg), or 0.01 mg/kg (30kg) or 1.25 mg/kg (&lt; 30 kg) SUBQ or IM; repeat x 1 in 15 min PRN no improvement.</li><li>• Diphenhydramine 25mg (&gt;30kg) or 1.25 mg/kg (&lt; 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.</li><li>• 0.9% Sodium Chloride 500 mL (&gt; 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.</li></ul>					
<b>Pre-Medication Orders</b>					
<input type="checkbox"/> Other: _____					
<b>Lab Orders</b>					
<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 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>					
<b>Prescriber Signature:</b> _____				<b>Date:</b> _____	
<b>Prescriber Information</b>					
<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>		
<b>Fax completed form, insurance information, and clinical documentation to: 1-331-551-7676</b>					
<small><b>CONFIDENTIAL HEALTH INFORMATION:</b> Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. <b>IMPORTANT WARNING:</b> This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners</small>					