ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800

Please mark the appropriate infusion center:

- ❑ Allenmore Infusion Center
- ❑ Auburn Infusion Center
- ❑ Gig Harbor Infusion Services
- ❑ Puyallup Infusion Center
- ❑ DHEC Infusion Center
- ❑ North Spokane Infusion Center
- ❑ North Star Lodge Infusion Center

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Lenacapavir (Yeztugo®)

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

ICD -10 Code:

Diagnosis: ❑ HIV preexposure prophylaxis ❑_____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

Baseline labs required:

❑ HIV-1 (HIV Ag/Ab and HIV 1 RNA) within 7 days before injection
❑ STI
❑ Hep B (surface Ab, core Ab, surface antigen)
❑ Hep C (prior history = C RNA quantitttive, no history = Ab screen)
*STI=GC/CT NAAT (urine, throat/rectal swab); Syphilis (prior hx=RPR for therapeutic response, no hx=Syphilis total Ab reflex)

Maintenance labs:

❑ HIV-1 within 7 days before injection
❑ STI

****Individuals who acquire HIV-1 while receiving Lenacapavir for PrEP must transition to a complete HIV-1 treatment regimen.**

Prophylaxis Treatment Regimen:

❑ Lenacapavir (Yeztugo®) 927 mg SUBQ day 1 then every 26 weeks (180 days)
❑ Lenacapavir (Yeztugo®) 600 mg PO Day 1 and 2 of Cycle 1 only (patient to use own medication through an outpatient prescription)

Administer Lenacapavir into the abdomen. The thigh can be used as an alternative injection site if preferred. Injections can be given up to 14 days before or 14 days after the official next injection date.

☑ **Vital Signs:** Check vital signs prior to and at completion of infusion.
Contact primary care provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4F)

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):

- Consult MultiCare Hypersensitivity guideline for treatment/management
- Notify primary care provider of reaction, assessment and need for further orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature	Print Name	Date	Time

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Order expires in 12 months****

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order
HIV PREEXPOSURE PROPHYLAXIS

MultiCare

62-1573-6 (2/26)