

Treatment Location: \_\_\_\_\_

**PROVIDERS: Please include the following to expedite the order:**

Patient Demographics; Insurance Information; All Clinical Documentation Supporting the Diagnosis Including any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing; HIV-1 Lab Results

## PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: \_\_\_\_\_ Patient Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

ICD-10 code (required): ☐ Z29.81 ☐ Z20.2 ☐ Z20.6 ☐ Z72.51 ☐ Z72.52 ☐ Z72.53 ICD Description: \_\_\_\_\_

Allergies: \_\_\_\_\_ Weight (lbs/kg): \_\_\_\_\_ Height: \_\_\_\_\_

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

## PROVIDER INFORMATION

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## NURSING

- ☒ Center will use Hypersensitivity protocol established by Infusion for Health and PI
- ☒ HIV-1 Lab Results (list results & attach clinicals) \_\_\_\_\_
- ☐ For initiation only, please confirm the oral tablet regimen has been prescribed to the patient by the referring provider (600mg on day 1 and day 2)

## PRE-MEDICATION ORDERS

Pre-medications not usually indicated.

- ☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
  - ☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650mg PO
  - ☐ Other: \_\_\_\_\_
- Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency: \_\_\_\_\_

## SPECIAL INSTRUCTIONS:

## LABORATORY ORDERS

- ☒ HIV-1 ☒ prior to each dose
- ☐ CBC ☐ at each dose ☐ every \_\_\_\_\_
- ☐ CMP ☐ at each dose ☐ every \_\_\_\_\_
- ☐ Other: \_\_\_\_\_ ☐ Frequency: \_\_\_\_\_
- ☐ Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

## THERAPY ADMINISTRATION

- ☒ Yeztugo Subcutaneous Injection
- Dose:**
  - ☐ Initiation (along with oral tablets prescribed by referring provider): 927mg on day 1
  - ☐ Continuation: 927mg every 6 months
- Doses may be given +/- 2 weeks from due date
- ☐ Refills: ☐ Zero / ☐ for 12 months / ☐ \_\_\_\_\_ (if not indicated, order will expire one year from date signed)

*To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.*

Provider Name (Print) \_\_\_\_\_ Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

- ☐ Please check this box if you DO NOT authorize Infusion for Health to complete a Peer-to-Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.