

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 INFORMATIONReferral 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)

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.

PRE-MEDICATION ORDERS

Pre-medications not usually indicated.

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

SPECIAL INSTRUCTIONS:**THERAPY ADMINISTRATION**

- Yeztugo
- Initiation:
 - Day 1: Yeztugo 927mg subcutaneous injection and Yeztugo 600mg PO
 - Day 2: Yeztugo 600mg PO
- Continuation: Yeztugo 927mg subcutaneous injection 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 _____
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- 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.