



Patient Information	
<b>Patient Name:</b>	<b>Phone:</b>
<b>Date of Birth:</b>	<b>Allergies:</b>
<b>Height:</b> <input type="checkbox"/> inches <input type="checkbox"/> cm	<b>Primary Diagnosis:</b>
<b>Weight:</b> <input type="checkbox"/> lbs <input type="checkbox"/> kg	<b>ICD-10 Code:</b>

**Guidelines for Prescribing**

Services provided by Home Infusion Pharmacy require the following orders below. Any changes in dose, change in therapy, or discontinuation of therapy should be communicated to OHSU Home Infusion Pharmacy at 503-346-3850. ***Rx is valid for 1 year from the date order is signed unless an earlier date is specified.***

**Pre-Screening (for new patients to OHSU Home Infusion only)- skip this section if patient has care established**

- Labs required to be drawn within 7 days prior to very first injection (send lab orders to patient's preferred outpatient lab). Once first injection is scheduled, OHSU Home Infusion will instruct patient to go to outpatient lab
  - HIV Ab/Ag
  - HIV Quant PCR
  - Outpatient lab: patient will use \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
  - Lab orders sent by clinic on this date: \_\_\_\_\_
- Patient weighs at least 35kg

**Oral Lead-In Dosing**

No safety and efficacy data are available for use of APRETUDE without an oral lead-in. However, in HIV-1 treatment clinical trials, data show that an oral lead-in is not needed to ensure adequate plasma cabotegravir exposure upon initiation of injections.

**Infusion Therapy**

**Medication (check mark required)**

**Cabotegravir ER (APRETUDE)**

**Is this the first dose?**

- Yes:
  - Is the patient receiving oral lead-in therapy?
    - Yes – medication & start date: \_\_\_\_\_
    - No
- No – last dose given: \_\_\_\_\_



- Initiation:** Cabotegravir ER (APRETUDE) 600mg IM once monthly for 2 doses. If oral lead-in is used, give the first dose of APRETUDE on the last day of oral lead-in or within 3 days after. The second dose of APRETUDE may be given up to 7 days before or after the scheduled administration date.
- Maintenance:** Cabotegravir ER (APRETUDE) 600mg IM every 2 months. Doses may be given up to 7 days before or after the scheduled administration date.

**Lenacapavir (YEZTUGO)**

**Is this the first dose?**

- Yes
- No – last dose given: \_\_\_\_\_

- Initiation:** Lenacapavir (YEZTUGO)
  - **Day 1:** 600 mg PO once + 927 mg SUBQ once
  - **Day 2:** 600 mg PO once
- Maintenance:** Lenacapavir (YEZTUGO) 927 mg SUBQ every 6 months (26 weeks) from date of the last injection ± 2 weeks. Doses may be given up to 14 days before or after the scheduled administration date.

**Additional comments:** \_\_\_\_\_

**Anaphylaxis Kit Orders (required)**

- Diphenhydramine 50 mg/mL vial  
Sig: 25-50 mg IV/IM, AS NEEDED for hypersensitivity or infusion reaction per protocol
- Epinephrine 1mg/mL vial  
Sig: 0.3 mg IM, AS NEEDED for hypersensitivity or infusion reaction per protocol
- 0.9% sodium chloride 500 mL bag  
Sig: Infuse 500 mL IV, AS NEEDED for hypersensitivity or infusion reaction per protocol
- Additional orders for adverse reactions:** \_\_\_\_\_

**Labs (optional) \*\*For OHSU HOME INFUSION med administration days only\***

- HIV Ab/Ag, Routine, every visit (required)
- Hepatitis C screening, Routine, every \_\_\_\_\_ (visit)(weeks)(months) – *Circle One*
- Gonorrhea/chlamydia, urine (self-collect), Routine, every \_\_\_\_\_ (visit)(weeks)(months) – *Circle One*
- Gonorrhea/chlamydia, throat swab (self-collect), Routine, every \_\_\_\_\_ (visit)(weeks)(months) – *Circle One*
- Gonorrhea/chlamydia, rectal swab (self-collect), Routine, every \_\_\_\_\_ (visit)(weeks)(months) – *Circle One*
- Gonorrhea/chlamydia, vaginal swab (self-collect), Routine, every \_\_\_\_\_ (visit)(weeks)(months) – *Circle One*
- Syphilis AB w/reflex titer (**no** history of syphilis), Routine, every \_\_\_\_\_ (visit)(weeks)(months) – *Circle One*
- RPR titer (history of syphilis), Routine, every \_\_\_\_\_ (visit)(weeks)(months) – *Circle One*
- CMP, Routine, every \_\_\_\_\_ (visit)(weeks)(months) – *Circle One*
- CBC with Differential, Routine, every \_\_\_\_\_ (visit)(weeks)(months) – *Circle One*
- Other labs: \_\_\_\_\_



**PRESCRIBER INFORMATION**

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Rx is valid for 1 year from date of signature. Refills will be provided to cover the duration of treatment unless otherwise indicated.*



Home Infusion

Phone: 503-346-3850

Fax: 503-346-3851

OHSU Home Infusion Nurses can only collect labs on days that they are administering medication. If patients require labs outside of these visits, please consider faxing orders to their preferred outpatient lab. This will be more important for labs required prior to start of care and for Yeztugo patients that are only seen by home infusion twice per year.

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Date of Birth:	ICD-10 Code:

**Labs \*\* Orders are valid for 1 year from date of signature\*\***

- HIV Ab/Ag, Routine, every visit (required)
- HIV quant PCR ONCE  
(Note to provider: required within 7 days prior to first dose for patients not on any form of PrEP OR optional to confirm HIV status as clinically necessary)
- Hepatitis C screening, Routine, every \_\_\_\_\_ (visit)(weeks)(months) – Circle One
- Gonorrhea/chlamydia, urine (self-collect), Routine, every \_\_\_\_\_ (visit)(weeks)(months) – Circle One
- Gonorrhea/chlamydia, throat swab (self-collect), Routine, every \_\_\_\_\_ (visit)(weeks)(months) – Circle One
- Gonorrhea/chlamydia, rectal swab (self-collect), Routine, every \_\_\_\_\_ (visit)(weeks)(months) – Circle One
- Gonorrhea/chlamydia, vaginal swab (self-collect), Routine, every \_\_\_\_\_ (visit)(weeks)(months) – Circle One
- Syphilis AB w/reflex titer (no history of syphilis), Routine, every \_\_\_\_\_ (visit)(weeks)(months) – Circle One
- RPR titer (history of syphilis), Routine, every \_\_\_\_\_ (visit)(weeks)(months) – Circle One
- CMP, Routine, every \_\_\_\_\_ (visit)(weeks)(months) – Circle One
- CBC with Differential, Routine, every \_\_\_\_\_ (visit)(weeks)(months) – Circle One
- Other labs: \_\_\_\_\_

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