

IBALIZUMAB-UIYK (TROGARZO®) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to: **(888) 410-2584**



Patient Name:		Date of Birth:		
Address:				
Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg

Clinical Information

Primary Diagnosis Description: Human immunodeficiency virus (HIV)	ICD-10 Code: B20
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Is this the first dose? Yes – date of first dose: _____ No – date of next dose due: _____

Ibalizumab-uiyk (Trogarzo®) Prescription

Ibalizumab-uiyk (Trogarzo®) 200 mg/1.33 mL vials refill as directed x 1 year

Loading Dose: Infuse 2000 mg IV over 30 minutes x 1 dose
 Repeat with 2000 mg IV over 30 minutes x 1 dose ASAP prn if patient misses a maintenance dose ≥ 3 days prior to resuming maintenance dose

Maintenance Dose: Infuse 800 mg IV over 15 minutes every 14 days
Flush IV catheter with NS 30 to 50 mL after each infusion.

Ancillary Orders

Anaphylaxis Kit
If this is a 1st dose, would you like Option Care to provide an anaphylaxis kit with the 1st dose?
 Yes – please complete Anaphylaxis Physician Order (FR-PC-036) No

Medication Orders
 Other: _____

IV Flush Orders

<input type="checkbox"/> <u>Peripheral:</u>	NS 2 to 3 mL pre-/post-use.
<input type="checkbox"/> <u>Peripheral-Midline:</u>	NS 3 to 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. Heparin (100 unit/mL) 3 mL post-use. For maintenance, flush with heparin (100 unit/mL) 3 mL every 24 hr.
<input type="checkbox"/> <u>PICC and Central Tunneled/Non-Tunneled:</u>	NS 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. Heparin <input type="checkbox"/> (10 unit/mL) 5 mL <u>or</u> <input type="checkbox"/> (100 unit/mL) 3 mL post-use. For maintenance, flush with heparin (10 unit/mL) 5 mL or (100 unit/mL) 3 mL every 24 hr.
<input type="checkbox"/> <u>Implanted Port:</u>	NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders
 No labs ordered at this time.
 Other: _____

Skilled nurse to administer doses intravenously. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:	Phone:	Fax:
Address:	NPI:	
City, State:	Zip:	Office Contact:

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