IBALIZUMAB-UIYK (TROGARZO®) PRESCRIBER ORDER FORM

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

YOUR INTELLIGENT HEALTH COMPANY. UBACARE

Patient Name:			**Date of Birth:**	
Address:				
Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description: Human immunodeficiency virus (HIV) | **ICD-10 Code:** B20

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

☐	Peripheral:	NS 2 to 3 mL pre-/post-use.
☐	Peripheral-Midline:	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.
☐	PICC and Central Tunneled/Non-Tunneled:	NS 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. Heparin ☐ (10 unit/mL) 5 mL *or* ☐ (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.
☐	Implanted Port:	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:**	

