

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

TROGARZO™ (Ibalizumab-uiyk) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:	Patient's Phone:
Patient Name:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG
Gender:	Allergies:
<input type="checkbox"/> See list	<input type="checkbox"/> NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

B20 - Human Immunodeficiency Virus (HIV) disease
_____ - Other:

REQUESTED DOCUMENTATION: PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		IF ORDER CHANGE: <input type="checkbox"/> Continue current order until insurance approved
5	Supporting clinical MD notes, Labs, and tests results supporting primary diagnosis		

MEDICATION ORDERS:

NOTE: We *may* require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.

MEDICATION:

TROGARZO™ (ibalizumab uiyk) administered IV

Follow each infusion with 30ml normal saline flush.

Extended one (1) hour post infusion monitoring after first treatment. If the patient does not experience any adverse reaction, then the post-infusion observation time can be reduced to 15 minutes for each subsequent infusion

DOSE/FREQUENCY:

Induction Dose: 2000 mg IV dose per 250ml NS over 30 minutes via pump

Maintenance Dose: 800 mg IV per 250ml NS every 14 days over 30 minutes via pump


Other: _____

If dosing is delayed by 3 days or longer, the referring physician will be notified.

SPECIAL ORDERS:

Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

<input checked="" type="checkbox"/> Start PIV/Access CVC <input checked="" type="checkbox"/> Flush device per facility standard flushing procedure <input checked="" type="checkbox"/> Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.	
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PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures) DATE:

Dispense as written/Brand medically necessary	Substitution permitted