

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 2<sup>ND</sup> AND 3<sup>RD</sup> 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		<b>IF ORDER CHANGE:</b> <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:

- Start PIV/Access CVC
- Flush device per facility standard flushing procedure
- Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

### ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.



### 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



## Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- Patient demographics - address, phone number, SS#, etc.**
- Insurance information - copy of the card(s) if possible**
- Plan of Treatment/Orders**
- Most recent physician office notes to include tried and failed therapies - all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- Any lab results or other diagnostic procedures to support the diagnosis.**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

[www.PalmettoInfusion.com](http://www.PalmettoInfusion.com)