Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071

ADULT AMBULATORY INFUSION ORDER

Lenacapavir (YEZTUGO) Injection for Pre-Exposure Prophylaxis (PrEP)

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Treatment Start Date: _____ Allergies: _____

Weight: _____kg Height: _____cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety

1. **FACE SHEET with complete INSURANCE information and patient CONTACT information**
2. **Recent VISIT NOTE to support treatment (if not available in Epic)**
3. **LAB RESULTS for any required prescreening (if not available in Epic)**
4. **DIAGNOSIS CODE _____**
5. **Patient NAME and DATE OF BIRTH on EVERY page faxed**

GUIDELINES FOR ORDERING

1. **Send FACE SHEET and H&P or most recent chart note.**
2. Lenacapavir (Yeztugo) is initiated in conjunction with oral lenacapavir. An outpatient prescription must be ordered by the referring provider and approved for patient prior to scheduling referral to infusion center. Lenacapavir oral tablets are not supplied by ambulatory infusion clinics.
3. Sunlenca and Yeztugo are not interchangeable. Yeztugo is indicated for HIV-1 infection preexposure prophylaxis.
4. Patients may develop immune reconstitution syndrome resulting in the occurrence of an inflammatory response to an indolent or residual opportunistic infection during initial HIV treatment or activation of autoimmune disorders later in therapy.
5. Residual concentrations of lenacapavir long-acting injection may remain in systemic circulation for 12 months or more. Risk of adverse reactions to drugs primarily metabolized CYP3A may be increased if initiated within 9 months after the last subcutaneous dose.
6. Injection site reactions may occur, and nodules and indurations may be persistent.

PRE-SCREENING

☑ HIV antibody/antigen results scanned with orders.
☑ HIV PCR screening results scanned with orders.

LABS:

1. HIV-1,2 AB/HIV-1 P24 AG SCRN, Routine, Clinic Connect, Once, Every Visit, Starting with the first dose.

NURSING ORDERS:

1. TREATMENT PARAMETER 1: Initiation dosing: Hold treatment and contact provider if patient does not have a prescription for oral lenacapavir or has not taken the oral initiation doses as prescribed.
2. TREATMENT PARAMETER 2: For initial dose: Hold treatment and contact provider if HIV AB/AG or PCR screening is reactive or has not been performed within 7 days of injection appointment. For subsequent dose: draw HIV AB/AG and proceed with treatment. Hold treatment and contact provider if previous results are reactive.
3. Nursing communication: Sunlenca and Yeztugo are not interchangeable.
4. Ignore duplicate labs if multiple of the same lab from different plans coincide on the same treatment day.

MEDICATIONS:

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- lenacapavir (PrEP) (YEZTUGO) injection, 927 mg, subcutaneous, ONCE, Every 26 Weeks
  YEZUTGO injection is for administration into the abdomen by a healthcare provider. Two 1.5 mL injections are required for a complete dose of 927 mg. Dispensed as 2 syringes (1.5 mL each). Administer each injection at separate sites in abdomen (2 or more inches from the navel).

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – if hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-PAT-133-GUD). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. Diphenhydramine (BENADRYL) injection, 25–50 mg, intravenous, AS NEEDED X 1 dose for hypersensitivity reaction.
3. EPINEPHrine HCl (ADRENALIN) injection, 0.5 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity reaction.
4. Hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction. Dilute vial by either pressing chamber for Act-O-Vial or diluting powder vial with 2 mL SWFI or NS for injection.
5. Famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose, for hypersensitivity reaction.

STAFF DIRECTIVES (as applicable):

1. Infusion staff to follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
2. Pharmacist to select appropriate admixture options including (as applicable) formulation, fluid base type, volume, concentration, administer-over time, and rate according to the package insert, drug information references, and facility policies, procedures, and practice standards.
3. Biosimilar substitutions may be permitted by infusion site policies or Collaborative Drug Therapy Management (CDTM) agreements. A pharmacist may substitute the biosimilar for authorized reasons, which may include infusion site preference or insurance reimbursement requirement. If it is NOT acceptable to substitute per site preference or insurance, check to Dispense as Written (DAW) ☐ and note the REQUIRED biosimilar: _____
4. Pharmacist may select or update orders to the site's preferred biosimilar. In addition, if insurance requires a specific biosimilar agent for reimbursement, pharmacy may update the order at sites with a Collaborative Drug Therapy Management agreement (CDTM). If it is NOT acceptable to substitute per site preference or insurance, check to Dispense as Written (DAW) ☐ and note the REQUIRED biosimilar: _____

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By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ **License #:** _____ **Date:** _____

Print Name: _____ **Phone:** _____ **Fax**:_____

Plan will expire 1 year after signature date at which time a new order will need to be placed

Contact the Referral Team directly for assistance at the centralized numbers below (do not contact individual clinics) **INFUSION REFERRAL TEAM** **Fax completed orders to (503) 346-8058** Phone (providers only) (971) 262-9645	☑ **Please indicate the patient's preferred clinic location below**	
	☐ **BEAVERTON** OHSU Knight Cancer Institute	15700 SW Greystone Court Beaverton OR 97006
	☐ **NW PORTLAND** Legacy Good Samaritan campus	Medical Office Building 3 – Suite 150 1130 NW 22nd Ave, Portland OR 97210
	☐ **GRESHAM** Legacy Mount Hood campus	Medical Office Building 3 – Suite 140 24988 SE Stark, Gresham OR 97030
	☐ **TUALATIN** Legacy Meridian Park campus	Medical Office Building 2 – Suite 140 19260 SW 65th Ave, Tualatin OR 97062
	☐ **Non-Legacy community providers only** **EAST PORTLAND** Adventist Health Portland campus	Pavilion – 10000 SE Main St – Suite 350 Portland, Oregon 97216
Infusion orders located at: www.ohsuknight.com/infusionorders	Referral team will consider other locations as appropriate if selected site is not available, if treatment is urgent, or for patient preference.	