
	<p align="center"><b>St. Charles Health System</b></p> <p align="center">Adult Ambulatory Infusion Order Lencapavir (Yeztugo) For Preexposure Prophylaxis (PrEP)</p>	<p>Patient Name: _____ Date of Birth: _____</p> <p align="right"><i>Patient Identification</i></p>
<b>ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK ( ✓ ) TO BE ACTIVE</b>		
<p><b>Treatment Start Date:</b> _____ <b>Allergies:</b> _____  <b>Weight:</b> _____ <b>kg</b> <b>Height:</b> _____ <b>cm</b></p> <p><b>REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety</b></p> <ol style="list-style-type: none"> <li><b>1. FACE SHEET with complete INSURANCE information and patient CONTACT information</b></li> <li><b>2. Recent VISIT NOTE to support treatment (if not available in Epic)</b></li> <li><b>3. LAB RESULTS for any required prescreening (if not available in Epic)</b></li> <li><b>4. DIAGNOSIS CODE</b> _____</li> <li><b>5. Patient NAME and DATE OF BIRTH on EVERY page faxed</b></li> </ol>		

**GUIDELINES FOR ORDERING**

1. Send FACE SHEET and H&P or most recent chart note.
2. Individuals must be tested for HIV-1 infection prior to initiating lencapavir, and with each subsequent injection of lencapavir, using a test approved or cleared by the FDA for the diagnosis of acute or primary HIV-1 infection. Do not initiate lencapavir for HIV-1 pre-exposure prophylaxis (PrEP) unless negative infection status is confirmed. Individuals who become infected with HIV-1 while receiving lencapavir for PrEP must transition to a complete HIV-1 treatment regimen.
3. For initiation dose, co-administration with oral lencapavir is required for days 1 and 2. Ensure patient has additional prescription for 600 mg tablets x2.
4. Contraindications: Hypersensitivity to lencapavir; Concomitant administration with strong CYP3A inducers; unknown or positive HIV-1 status (when used for HIV-1 preexposure prophylaxis).
5. Carefully select individuals who agree to the required injection dosing and testing schedule and counsel individuals about the importance of adherence to scheduled dosing visits to help reduce the risk of acquiring HIV-1 infection and development of resistance.

**NURSING ORDERS:**

1. TREATMENT PARAMETER #1- HIV testing must be negative before initiation and each subsequent injection.
2. TREATMENT PARAMETER #2- For initial dose, ensure patient has filled prescription for required oral tablets prior to administration.
3. Injection-site reactions (ISRs) have been reported in patients using SUBQ lenacapavir. Most reactions were described as mild or moderate (grade 1 or 2), although severe (grade 3) events were also reported. Reactions have included erythema at injection site, induration at injection site, injection-site nodule, pain at injection site, and swelling at infection site.
4. Monitor and record vital signs, tolerance, and presence of injection-related reactions.
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes

	<p align="center"><b>St. Charles Health System</b></p> <p align="center">Adult Ambulatory Infusion Order Lencapavir (Yeztugo) For Preexposure Prophylaxis (PrEP)</p>	<p>Patient Name: Date of Birth:</p> <p align="right"><i>Patient Identification</i></p>
<p align="center"><b>ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK ( ✓ ) TO BE ACTIVE</b></p>		

**MEDICATIONS:**

Initiation injections:

Initiation dosing is required. Completion of the initiation dosing schedule requires both SUBQ injections and oral tablets; use caution to ensure appropriate dose and dosage form on the appropriate day of therapy.

Lencapavir (Yextugo) injection, 927 mg, subcutaneous, once. Two 1.5 mL SUBQ injections are required for a complete dose; insert needle into pinched skin between a 45-degree (acceptable) to 90-degree (preferred) angle and inject slowly and carefully due to solution viscosity. Administer each injection SUBQ at separate sites  $\geq 4$  inches apart in the abdomen ( $\geq 2$  inches from the navel); the thigh may be used as an alternative injection site if preferred.

Continuation injections:

Lencapavir (Yextugo) injection, 927 mg, subcutaneous, once every 6 months, starting 6 months after the last injection. Two 1.5 mL SUBQ injections are required for a complete dose; insert needle into pinched skin between a 45-degree (acceptable) to 90-degree (preferred) angle and inject slowly and carefully due to solution viscosity. Administer each injection SUBQ at separate sites  $\geq 4$  inches apart in the abdomen ( $\geq 2$  inches from the navel); the thigh may be used as an alternative injection site if preferred.

Continuation injections may be administered up to 14 days before or after the date the individual is scheduled to receive the injection.

**INFUSION MONITORING/REACTION:**

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebulizer, AS NEEDED x1 dose for hypersensitivity reaction

Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

---



**St. Charles Health System**

Adult Ambulatory Infusion Order  
Lencapavir (Yeztugo)  
For Preexposure Prophylaxis (PrEP)

Patient Name:

Date of Birth:

*Patient Identification*

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

Patient will be treated at the following infusion location:

- St. Charles Outpatient Infusion Center  
2500 NE Neff Road, Bend, OR 97701  
Phone: (541) 706-5820 Fax: (541) 706-5825

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**