Lenacapavir (Yeztugo)

Provider Order Form rev. 04/27/2026

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

HIV PrEP:

Other: Description:

THERAPY ADMINISTRATION & DOSING

☐ Induction and Maintenance: Day 1: 927 mg by subcutaneous injection (2 x 1.5 mL injections) and 600 mg orally (2 x 300 mg tablets) Day 2: 600 mg orally (2 x 300 mg tablets) administered in clinic. Then proceed to maintenance dosing: Inject 927mg (2x 1.5-mL injections) subcutaneously every 6 months from date of last injection +/- 2 weeks.

☐ Maintenance Only: Inject 927mg (2 x 1.5-mL injections) subcutaneously every 6 months from date of last injection +/- 2 weeks

PRE-MEDICATION ORDERS

☐ Other: _____

ADDITIONAL ORDERS

LABORATORY ORDERS

☑ HIV-1 RNA within 7 days prior to each dose, results must be available and reviewed before injecting.

NURSING

☑ Hold infusion and notify provider for:

- Positive HIV-1 test
- Unknown HIV-1 status
- Patients weighing less than 35kg
- Lack of compliance

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation.

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including negative HIV test,treatment failures or contraindications, and evidence of compliance on current therapy.

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.