



**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Sex:  M  F Ht: \_\_\_\_\_ Wt: \_\_\_\_\_  lbs  kg  
 Primary Language: \_\_\_\_\_ Allergies: \_\_\_\_\_

**<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION**

**ICD 10 Code (PROVIDE COMPLETE CODE)**  
 B20 Human Immunodeficiency Virus (HIV)  
 Z21 Asymptomatic HIV infection  
 Other: \_\_\_\_\_

**REQUIRED:** Demographics & Most Recent: H&P, clinical notes, labs, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy

**PRESCRIPTION**

**Pre-Medications**

- |   |  |
|---|--|
| <input type="checkbox"/> Acetaminophen: 650 mg PO   | <input type="checkbox"/> Acetaminophen: _____ mg PO      |
| <input type="checkbox"/> Cetirizine 10 mg PO        | <input type="checkbox"/> Famotidine: _____ mg IV         |
| <input type="checkbox"/> Dexamethasone: _____ mg IV | <input type="checkbox"/> Loratadine 10 mg PO             |
| <input type="checkbox"/> Diphenhydramine: 25 mg PO  | <input type="checkbox"/> Methylprednisolone: _____ mg IV |
| <input type="checkbox"/> Diphenhydramine: 25 mg IV  | <input type="checkbox"/> Other: _____                    |

**Lab Orders**

- CBC w/diff: every \_\_\_\_\_  weeks  month  
 CMP: every \_\_\_\_\_  weeks  month  
 HIV-1 RNA, PCR : \_\_\_\_\_  weeks  month  
 Other: \_\_\_\_\_  weeks  month

**Cabenuva (cabotegravir/rilpivirine)**

**Loading Dose (SELECT ONE)**

IM: inject 600 mg/3mL of cabotegravir and 900 mg/3mL of rilpivirine intramuscularly at week 0 and week 4

**Maintenance Dosing (SELECT ONE)**

IM: inject 600 mg/3mL of cabotegravir and 900 mg/3mL of rilpivirine intramuscularly every 8 weeks x 1 year

**Sunlenca (lenacapavir)**

**Loading Dose (SELECT ALL THAT APPLY)**

- Day 1: inject 927 mg subcutaneously along with taking 600 mg orally  
 Day 2: 600 mg orally (patient can take at home or return to clinic for observation)  
 Other: \_\_\_\_\_

**Maintenance Dose (SELECT ONE)**

SQ: inject 927 mg subcutaneously once every 6 months x 1 year

**Adverse Events:** In the event of an adverse reaction occurring at Oregon Specialty Infusion clinic, OSI will utilize their adverse reactions protocol

Is the patient on any other disease modifying therapy?  Yes  No

If yes, please note therapy and last dose: \_\_\_\_\_

**PRESCRIBING INFORMATION**

Prescriber Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Date: \_\_\_\_\_ NPI # \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Office phone #: \_\_\_\_\_ Office Fax #: \_\_\_\_\_