AMERICAN INFUSION CARE
SPECIALTY INFUSION

Yeztugo (Lencapavir)

Provider Order Form *rev. 1/2/2026*

PATIENT INFORMATION

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

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

☐ NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

☐ICD10 Z29.81 Encounter for HIV pre-exposure prophylaxis
☐ICD10 Z72.51 High-risk heterosexual behavior
☐ICD10 Z72.52 High-risk homosexual
☐ICD10 Z72.53 High-risk bisexual behavior
☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
☐ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

☐ Acetaminophen (Tylenol) ☐500mg ☐650mg ☐ 1000mgPO
☐ Cetirizine (Zyrtec) 10mgPO
☐ Loratadine (Claritin) 10mgPO
☐ Diphenhydramine (Benadryl) ☐25mg ☐50mg ☐ PO ☐ IV
☐ Methylprednisolone (Solu-Medrol) ☐40mg ☐125mg IV
☐ Other: _____ Dose: _____ Route: _____

Lab Orders

*Required:*HIV-1RNA, 4th gen HIV Ag/Ab Test
Optional Labs: Hep B Panel, Hep C Ab; STI screening (gonorrhea, chlamydia, syphilis), Pregnancy test (if applicable)
☐ Other: _____

Yeztugo (lenacapavir) (Select one):

Initial Dose:

☐ 927 mg subcutaneous injection | Quantity: 2 x 1.5 mLs | Refills: 1
Oral 300 mg tablets | Quantity: 4 | Refills: 0

Scan for more locations!

Maintenance Dose:

☐ 927 mg subcutaneous injection every 6 months x 1 year | Quantity: 2 x 1.5 mLs | Refills: 1

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

☐ **Refills:** ☐ zero ☐6 months ☐12 months ☐ _____ *(Prescription valid for one year, unless otherwise indicated)*

Special Instructions: _____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print) *Provider Signature* *Date*