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

PO7071

ADULT AMBULATORY INFUSION ORDER

Ibalizumab-uiyk (TROGARZO) Infusion

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. The patient should have heavily treated multi-drug resistant HIV-1 disease, confirmed by resistance testing, and failing their current anti-retroviral regimen.
3. Treatment should be initiated in combination with other antiretroviral(s) to which the patient's HIV-1 strain is known to be sensitive/susceptible, as confirmed by resistance testing.
4. The patient should have a baseline viral load > 1,000 copies/mL on at least two consecutive assessments within the preceding trimester.
5. Immune Reconstitution Inflammatory Syndrome (IRIS) has been reported in patients treated with ibalizumab-uiyk. Patients may develop an inflammatory response to indolent or residual opportunistic infections during the initial phase of combination antiretroviral therapies, necessitating further evaluation and treatment.
6. If a maintenance dose (800 mg) is missed by 3 days or longer beyond the scheduled dosing day, a loading dose (2 g) should be administered as soon as possible. Resume maintenance dosing every 14 days thereafter.

NURSING ORDERS:

1. NURSING COMMUNICATION – HYPERSENSITIVITY/INFUSION REACTION -- Monitor patient for 1 hour after the first infusion. If there are no infusion related reactions, the post-administration observation period may be reduced to 15 minutes for maintenance doses.
2. Administer initial infusion (loading dose) over ≥ 30 minutes. If no infusion related reactions are observed, subsequent maintenance doses may be administered as IV push over 30 seconds.

MEDICATIONS:

Loading Dose (IV Infusion):

Ibalizumab-uiyk (TROGARZO) 2,000 mg in sodium chloride 0.9%, intravenous, ONCE, infuse 2,000 mg loading dose over 30 minutes. Administer in the cephalic vein.

Maintenance Dose (IV Push):

Ibalizumab-uiyk (TROGARZO) injection 800 mg, intravenous, ONCE, every 2 weeks beginning 2 weeks after loading dose, administer 800 mg IV push into cephalic vein.

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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, HMC C-132). 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 x1 dose for hypersensitivity reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

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OLC Central Intake Nurse:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient's preferred clinic location:

☐ **Beaverton**
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

☐ **NW Portland**
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

☐ **Gresham**
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

☐ **Tualatin**
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders