RESTORE HEALTH
INFUSION AND WELLNESS

SUNLENCA

Please include the following to expedite the order:
Patient Demographics, Insurance Information, HIV Labs

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ **DOB:** _____ **Gender:** ☐ M ☐ F ☐ Other _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

PRESCRIBER

Name: _____ **DEA:** _____ **NPI:** _____ **State License:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

CLINICAL

Diagnosis: ☐ B20 (HIV Disease) ☐ Other: _____

Allergies: _____ **Weight:** _____ ☐ kg ☐ lbs **Height:** _____ ☐ cm ☐ in

HBV: ☐ Yes ☐ No **Initiation completed by referring provider?** ☐ Yes ☐ No Date: _____

HIV Labs Completed: ☐ Yes ☐ No Date Completed: _____ *If yes, please attach all labs to form*

TREATMENT

SUNLENCA (lenacapavir)

Route: Subcutaneous Injection

Dose: ☐ 927mg

Frequency:

☐ Initial: 927mg once
Following completion of the prescribed oral loading regimen or per FDA-approved initiation regimen

☐ Maintenance: 927mg every 6 months
Doses may be given +/- 2 weeks from due date

Quantity: _____ **Refills:** _____

Premedication Protocol: *(Not Usually Indicated)*

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ Other: _____

Sig: _____

■ *Center will use anaphylactic and hypersensitivity protocol established by Restore Health*

Special Instructions: _____

_____

_____

_____

Provider Signature: _____ Date: _____