Postpartum Physician Orders for HIV Patients Only
Family Birth Center

Name
DOB
MRN
PCP

Patient ID/Addressograph

Adverse Drug Events (including allergies): ________________________________
Non-Drug Allergies: ________________________________

ANTIRETROVIRAL Orders
Post-delivery: All previous antiretroviral medications are discontinued and must be re-ordered if indicated

Indication for antiretroviral medications:

☐ Maternal prophylaxis (PrEP or PEP)
☐ Maternal treatment

☐ Atazanavir 300 mg PO once daily AND Ritonavir 100 mg PO once daily (note dosage change post-partum)
☐ Atripla (efavirenz 600 mg/ emtricitabine 200 mg/ tenofovir 300 mg) 1 tab PO at bedtime
☐ Complera (emtricitabine 200 mg/ tenofovir 300 mg/ rilpivirine 25 mg) 1 tab PO once daily w/ a meal
☐ Darunavir 800 mg PO once daily AND Ritonavir 100 mg PO once daily
☐ Descovy (emtricitabine 200 mg/tenofovir alafenamide 25 mg) 1 tab PO once daily
☐ Dolutegravir 50 mg PO once daily
☐ Epzicom (abacavir 600 mg/lamivudine 300 mg) 1 tab PO once daily
☐ Evotaz (atazanavir 300 mg/cobicistat 150 mg) 1 tab PO once daily with food
☐ Genvoya (elvitegravir 150 mg/cobicistat 150 mg/emtricitabine 200 mg/tenofovir alafenamide 10 mg) 1 tab PO daily with food
☐ Odefsey (emtricitabine 200 mg/ rilpivirine 25 mg/tenofovir alafenamide 25 mg) 1 tab PO once daily with a meal
☐ Prezco (darunavir 800 mg/cobicistat 150 mg) 1 tab PO daily with food
☐ Raltegravir 400 mg PO BID
☐ Strive (elvitegravir 150 mg/cobicistat 150 mg/ emtricitabine 200 mg/tenofovir 300 mg) 1 tab PO once daily with a meal
☐ Triumeq (abacavir 600 mg/ dolutegravir 50 mg/lamivudine 300 mg) 1 tab PO once daily
☐ Truvada (emtricitabine 200 mg/ tenofovir 300 mg) PO 1 tab once daily

ANTIBIOTIC Orders
☐ Azithromycin 1200 mg PO once weekly on __________________________ (day of week)
☐ Sulfamethoxazole 800 mg/trimethoprim 160 mg (Septra) 1 tab PO once daily

ADDITIONAL Orders
☐ Cabergoline 1 mg PO x 1 within 24 hours of delivery for lactation suppression
☐ Offer supportive bra and ice to reduce likelihood of lactation
☐ Remove all breastfeeding literature from patient education packet
☐ Please see Post-Partum Order form for additional orders
☐ Schedule postpartum visit w/ __________________ (provider) @ 5MHIVE for _____ weeks postpartum

Date: _____ Time: _______ Provider: __________________________ /________________________ / CHN ID# __________________
Print name Signature Title

Date: _____ Time: _______ UC: _______________________________/________________________ / INV# __________________
Print name Signature

Date: _____ Time: _______ RN: ____________________________/____________________________ / INV# __________________
Print name Signature