Location: _____

Labs

Labs

☐ **All newborns with suspected HIV: HIV-1 RNA, qualitative TMA** Once, 1, Occurrences, S, Routine, Blood, 3
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **If maternal HIV testing is not available: HIV 1/2 antigen/antibody, fourth generation, with reflexes** Once, 1, Occurrences, S, Routine, Blood, 3, This is non-diagnostic
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **CBC with platelet and differential** Once, 1, Occurrences, S, Routine, Blood, 3, Newborn with high-risk of perinatal HIV transmission and started on 3-drug regimen.

Medication

Medication Orders (Required)

○ **Low-Risk of Perinatal HIV Transmission: Single-Drug Regimen** (Required)
Who meet ALL low-risk criteria

☑ **zidovudine (RETROVIR) syrup** (Required)

○ **Gestational Age GREATER than or EQUAL to 37 Weeks ***

○ **zidovudine (RETROVIR) 10 mg/mL syrup**

◉ **zidovudine (RETROVIR) 10 mg/mL syrup** 10 , 2 times daily
Indication:

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◉ **zidovudine (RETROVIR) 10 mg/mL syrup** 10 , 2 times daily
Indication:

○ **Gestational Age GREATER than or EQUAL to 35 Weeks to LESS than 37 Weeks**

○ **zidovudine (RETROVIR) 10 mg/mL syrup**

◉ **zidovudine (RETROVIR) 10 mg/mL syrup** 10 , 2 times daily
Indication:

○ **zidovudine (RETROVIR) 10 mg/mL syrup**

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Indication:

○ **zidovudine (RETROVIR) 10 mg/mL syrup**

◉ **zidovudine (RETROVIR) 10 mg/mL syrup** 10 , 2 times daily
Indication:

○ **Gestational Age GREATER than or EQUAL to 30 Weeks to LESS than 35 Weeks**

☑ **zidovudine (RETROVIR) 10 mg/mL syrup**

◉ **zidovudine (RETROVIR) 10 mg/mL syrup** 10 , 2 times daily
Indication:

☑ **zidovudine (RETROVIR) 10 mg/mL syrup**

◉ **zidovudine (RETROVIR) 10 mg/mL syrup** 10 , 2 times daily
Indication:

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

- ○ **Gestational Age LESS than 30 Weeks**
  - ☑ **zidovudine (RETROVIR) 10 mg/mL syrup**
    - ◉ **zidovudine (RETROVIR) 10 mg/mL syrup** 10 , 2 times daily
      Indication:
  - ☑ **zidovudine (RETROVIR) 10 mg/mL syrup**
    - ◉ **zidovudine (RETROVIR) 10 mg/mL syrup** 10 , 2 times daily
      Indication:

○ **High-Risk of Perinatal HIV Transmission: Three-Drug Regimen** (Required)

***Who meet ALL high-risk criteria**

- ☑ **zidovudine (RETROVIR) syrup** (Required)
  - ○ **Gestational Age GREATER than or EQUAL to 35 Weeks**
    - ○ **zidovudine (RETROVIR) 10 mg/mL syrup**
      - ◉ **zidovudine (RETROVIR) 10 mg/mL syrup** 10 , 2 times daily
        Indication:
    - ○ **zidovudine (RETROVIR) 10 mg/mL syrup**
      - ◉ **zidovudine (RETROVIR) 10 mg/mL syrup** 10 , 2 times daily
        Indication:
    - ○ **zidovudine (RETROVIR) 10 mg/mL syrup**
      - ◉ **zidovudine (RETROVIR) 10 mg/mL syrup** 10 , 2 times daily
        Indication:
    - ○ **zidovudine (RETROVIR) 10 mg/mL syrup**
      - ◉ **zidovudine (RETROVIR) 10 mg/mL syrup** 10 , 2 times daily
        Indication:
  - ○ **Gestational Age GREATER than or EQUAL to 30 Weeks to LESS than 35 Weeks**
    - ☑ **zidovudine (RETROVIR) 10 mg/mL syrup**
      - ◉ **zidovudine (RETROVIR) 10 mg/mL syrup** 10 , 2 times daily
        Indication:
    - ☑ **zidovudine (RETROVIR) 10 mg/mL syrup**
      - ◉ **zidovudine (RETROVIR) 10 mg/mL syrup** 10 , 2 times daily
        Indication:
  - ○ **Gestational Age LESS than 30 Weeks**
    - ☑ **zidovudine (RETROVIR) 10 mg/mL syrup**
      - ◉ **zidovudine (RETROVIR) 10 mg/mL syrup** 10 , 2 times daily
        Indication:
    - ☑ **zidovudine (RETROVIR) 10 mg/mL syrup**
      - ◉ **zidovudine (RETROVIR) 10 mg/mL syrup** 10 , 2 times daily
        Indication:
- ☑ **lamiVUDine (EPIVIR) solution** (Required)
  - ◉ **Gestational Age GREATER than or EQUAL to 32 Weeks**
    - ☑ **lamiVUDine (EPIVIR) 10 mg/mL solution**
      - ◉ **lamiVUDine (EPIVIR) 10 mg/mL solution** 10
        Indication:
    - ☑ **lamiVUDine (EPIVIR) 10 mg/mL solution**
      - ◉ **lamiVUDine (EPIVIR) 10 mg/mL solution** 10
        Indication:
- ☑ **nevirapine (VIRAMUNE) suspension** (Required)

Sign:______________________ **Printed Name:**______________________ **Date/Time:**________

○ **Gestational Age GREATER than or EQUAL to 37 Weeks**

◉ **nevirapine (VIRAMUNE) 50 mg/5 mL suspension**

◉ **nevirapine (VIRAMUNE) 50 mg/5 mL suspension** 50 , 2 times daily
Indication:

○ **Gestational Age GREATER than or EQUAL to 34 Weeks to LESS than 37 Weeks**

Dose increase only for infants with confirmed HIV infection

☑ **nevirapine (VIRAMUNE) 50 mg/5 mL suspension**

◉ **nevirapine (VIRAMUNE) 50 mg/5 mL suspension** 50 , 2 times daily
Indication:

☑ **nevirapine (VIRAMUNE) 50 mg/5 mL suspension**

◉ **nevirapine (VIRAMUNE) 50 mg/5 mL suspension** 50 , 2 times daily
Indication:

○ **Gestational Age GREATER than or EQUAL to 32 Weeks to LESS than 34 Weeks**

☑ **nevirapine (VIRAMUNE) 50 mg/5 mL suspension**

◉ **nevirapine (VIRAMUNE) 50 mg/5 mL suspension** 50 , 2 times daily
Indication:

☑ **nevirapine (VIRAMUNE) 50 mg/5 mL suspension**

◉ **nevirapine (VIRAMUNE) 50 mg/5 mL suspension** 50 , 2 times daily
Indication:

☑ **nevirapine (VIRAMUNE) 50 mg/5 mL suspension**

◉ **nevirapine (VIRAMUNE) 50 mg/5 mL suspension** 50 , 2 times daily
Indication:

Sign:_____ **Printed Name:**_____ **Date/Time:**_____