CAR-T Cell Therapy Infectious Disease Prophylaxis Protocol	
Antibacterial	Levofloxacin 500mg daily (or renally dosed if CrCl <50)
Antifungal	 Begin when ANC < 500, discontinue when ANC >500 Fluconazole 400mg daily (or renally dosed if CrCl <50) Begin at Day 0, continue through Day +30 If prolonged neutropenia > 14 days post-CART or history of mold infection, switch to posaconazole DR 300mg daily If CRS (ICANS) >3, strongly consider changing to anti-mold prophylaxis with posaconazole
Antiviral	 Valacyclovir 500mg BID or Acyclovir 800 mg PO BID (or renally dosed if CrCl <50) starting on Day -5 (with initiation of lymphodepleting chemotherapy) and continue through 6-12mo (as long as CD4 > 200 at that time)
Pneumocystis	 TMP-SMX 1 DS M/W/F or TMP-SMX 1 SS daily starting on neutrophil engraftment (typically days +21 to +28) through Day +180 (as long as CD4 > 200 at that time) If unable to tolerate sulfa, Atovaquone 1500mg daily or dapsone 100mg daily (if G6PD normal)
Hepatitis B^ Only for hep B Core Ab +	Tenofovir alafenamide 25mg daily or entecavir 0.5mg daily or lamivudine 100mg daily (or renally dosed for CrCl <50) • Start at beginning of chemotherapy (D-5), continue through CAR-T therapy and at least 6mos*

Alimited data available on outcomes among HBV infected patients with cirrhosis who get CAR-T therapy

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^{*}B cell aplasia can be prolonged and there are no data at this time on T cell immune reconstitution after anti-CD19 CAR-T therapy-- therefore would consider continuing antiviral ppx long-term given reported incidence of HBV reactivation in patients who discontinued ppx 1 yr post-CAR-T