immersiv HEALTH

PEMGARDA® ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information

☐ List of Medications

☐ Most Recent History & Physical

MEDICATION ORDER

☐ **INITIAL DOSE:** PEMGARDA® (pemivibart) 4500 mg IV in 50 ml NS with .22 micron filter over 60 minutes

☐ **REPEAT DOSING:** PEMGARDA® (pemivibart) 4500 mg IV in 50 ml NS with .22 micron filter over 60 minutes every 3 months

* Patient to be observed for two (2) hours following each infusion.

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE:

_____

PRE-MEDICATIONS

PO

☐ Acetaminophen: 650 mg
☐ Cetirizine: 10 mg
☐ Diphenhydramine: 25 mg

IV

☐ Methylprednisolone: 125 mg
☐ Diphenhydramine: 25 mg

☐ **OTHER:** _____ ☐ PO ☐ IV

Patient to be observed for two (2) hours following each infusion. Administer per protocol.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ **CONTACT NAME:** _____
(IF APPLICABLE)

SIGNATURE: _____ | _____ **DATE:** _____
(NO STAMPS)
SUBSTITUTION PERMITTED DISPENSE AS WRITTEN