Local Infusion

MYLOCALINFUSION.COM

PEMGARDA (PEMIVIBART) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____ kg

Allergies: _____

❑ Patient has known difficult venous access. Comments: _____

❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

❑ Pre-exposure prophylaxis of coronavirus disease 2019 (COVID-19) in adults and adolescents (12 years of age) who have moderate-to-severe immune compromise, ICD 10: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO

❑ Benadryl 25mg PO

❑ Famotidine 20 mg IV

❑ Cetirizine (Zyrtec) 10 mg PO

❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Pemgarda	❑ Initial Dose: 4500 mg administered as a single intravenous infusion. ❑ Repeat Dose: 4500 mg administered as a single intravenous infusion approximately every 3 months.	IV	q 3 months

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

FAX NUMBERS:

❑ CT: 203.433.0621
❑ FL: 904.877.9270
❑ MA: 413.296.8482
❑ MD: 240.224.8607
❑ ME: 207.407.7272
❑ NC: 919.984.8698
❑ NH: 603.217.5371
❑ NJ: 201.581.4521
❑ NY: 631.250.6020
❑ OH: 937.871.4594
❑ PA: 610.273.5998
❑ SC: 864.973.6279
❑ VA: 703.202.0499