

Los Angeles, CA  
2080 Century Park East  
Suite 710  
Los Angeles, CA 90067



# PEMGARDA (pemivibart)

## ORDER FORM

Date: \_\_\_\_\_

### PATIENT INFORMATION

Name:	Phone:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
<input type="checkbox"/> NKDA Allergies:		Weight lbs/kg:	

### PHYSICIAN INFORMATION

Physician Name:	Practice Name:		
Address:	Office Contact Name:	Office Contact #:	
Phone:	Fax:	Email (for updates):	

### REFERRAL STATUS

New Referral    Referral Renewal    Medication/Order Change    Benefits Verification Only    Discontinuation Order

**PEMGARDA:** injection, for intravenous use.

The U.S. Food and Drug Administration (FDA) has issued an EUA for the emergency use of the unapproved product PEMGARDA for the pre-exposure prophylaxis of COVID-19 in adults and adolescents (12 years of age and older weighing at least 40 kg):

- Who are not currently infected with SARS-CoV-2 and who have not had a known recent exposure to an individual infected with SARS-CoV-2 **and**
- Who have moderate-to-severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments **and** are unlikely to mount an adequate immune response to COVID-19 vaccination.

- ICD-10\*: \_\_\_\_\_
- Dx Code: \_\_\_\_\_
- Dx Code: \_\_\_\_\_

#### PRE-MEDICATION

- Tylenol PO 650mg    1000mg    other \_\_\_\_\_
- Solumedrol 125mg IV    other \_\_\_\_\_
- Benadryl    25mg    50mg    other \_\_\_\_\_    IV    PO
- Medication \_\_\_\_\_ Dose \_\_\_\_\_ Route \_\_\_\_\_
- \_\_\_\_\_ (other)    \_\_\_\_\_ (other)

### WARNINGS AND PRECAUTIONS

<https://invivyd.com/wp-content/uploads/2024/09/EUA-122-Grant-Revised-FS-for-HCP.pdf>

### PEMGARDA ORDERS

#### PATIENT WEIGHT

\_\_\_\_\_ lbs.  
\_\_\_\_\_ kg

- Initial dosage of PEMGARDA in adults and adolescents (12 years of age and older weighing t least 40 kg) is 4500mg
- Repeat 4500mg of PEMGARDA administered every 3 months x \_\_\_\_\_ doses

- Clinically monitor patients during infusion and observe patients for at least 2 hours after infusion is completed.

### NOTES/ADDITIONAL COMMENTS:

### REQUIRED DOCUMENTATION CHECKLIST:

- \_\_\_\_ Patient Demographics
- \_\_\_\_ Insurance Card/Information
- \_\_\_\_ Recent Labs
- \_\_\_\_ Recent Progress and Vaccination Status
- \_\_\_\_ Other

#### ORDERING PROVIDER

Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Diagnosis Code: \_\_\_\_\_  
Order/dosage: \_\_\_\_\_  
Signature: \_\_\_\_\_