Philadelphia/Center City
1528 Walnut Street
Suite 1205
Philadelphia, PA 19102

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

Philadelphia/King Of Prussia
216 Mall Blvd
Suite#1
King Of Prussia, PA, 19046

PEMGARDA (pemivibart) ORDER FORM

Date: ____________________

PATIENT INFORMATION

Name:	Phone:	DOB:	SEX: M ☐ F ☐
☐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)*

NOTES/ADDITIONAL COMMENTS:

WARNINGS AND PRECAUTIONS

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

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.

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: ______________________