Connecticut
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Greenwich, CT 06830

ThrIVewell™ INFUSION
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Mission Medical

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)*

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.

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: _____