

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.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.

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: _____