Pemgarda™ for Emergency Use Authorization (EUA) ONLY
Provider Order Form Rev. 05/2024
Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

Diagnosis resulting in patient being immunocompromised:

☐ _____, ICD10 _____ ☐ _____, ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Pemgarda™ (pemivibart)	4500 mg	Infuse IV over 60 minutes once every 3 months x 1 year *Observe patient for 2 hours after completion of infusion

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment:_____ Date of next treatment:_____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP

☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____

☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ NPI:_____ TIN:_____ Specialty:_____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

☐ The patient is not currently infected with SARS-CoV-2 and has no known recent exposure to an individual infected with SARS-CoV-2.

☐ The patient is moderately-to-severely immune compromised due to a medical condition or receipt of immunosuppressive medications/treatments and is unlikely to mount an adequate immune response to COVID-19 vaccination.

Please specify reason(s) for immunosuppression:

- ☐ Active treatment for solid tumor and hematologic malignancies
- ☐ Hematologic malignancies associated with poor responses to COVID-10 vaccines regardless of current treatment status
- ☐ Receipt of solid-organ transplant or an islet transplant and taking immunosuppressive therapy
- ☐ Receipt of chimeric antigen receptor (CAR)-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppressive therapy)
- ☐ Moderate or severe primary immunodeficiency
- ☐ Advanced or untreated HIV infection
- ☐ Active treatment with high-dose corticosteroids, alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, and biologic agents that are immunosuppressive or immunomodulatory
- ☐ Other: _____