Pemivibart (Pemgarda)

Provider Order Form rev. 8/26/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

SARS-CoV-2 prophylaxis for COVID-19:

Other: Description:

DIAGNOSIS TO SUPPORT IMMUNOCOMPROMISED STATUS *(Required)*

Other: Description:

THERAPY ADMINISTRATION AND DOSING

☑ Administer Pemivibart (Pemgarda) 4500mg IV over 60 minutes.

☑ Clinically monitor patient during infusion and for 2 hours after infusion is completed.

FREQUENCY *(Choose one)*

☐ Every 3 months

☐ Other: _____

LABORATORY ORDERS

☐ Other: _____

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO

☐ Loratadine 10mg PO

☐ Pepcid 20mg ☐ PO / ☐ IVP

☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP

☐ Solumedrol ☐ 40mg / ☐ 125mg IVP

☐ Other: _____

NURSING

☑ Hold infusion and notify provider:

- Pt must be 12 years of age or older and weigh greater than 40kg.
- Hold if there has been an exposure to someone with covid.
- Hold if less than two weeks from covid vaccine.
- If there is a history of severe hypersensitivity reaction to the covid vaccine, consider consult with an allergist prior to infusion of pemgarda.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

☑ Submit serious adverse event and medication error reports using FDA form 3500

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications. COVID-19 Testing

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.