INFUSACARE
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Pemgarda (Pemivibart) Infusion Order

Patient Name: DOB: □ Male □ Female

Diagnosis (please provide ICD10 code):

□ Other:

□ NKDA □ Allergies:

□ New Therapy Order □ Continuation of Therapy Date of last dose:

Ordering Provider Name:

Provider NPI: Phone: Fax:

Practice Address: City: State: Zip Code:

Pre-Medication

□ Acetaminophen _____mg by □ PO

□ Cetirizine _____mg by □ PO

□ Diphenhydramine _____mg by □ PO/ □ IVP

□ Solu-Medrol _____mg by □ PO/ □ IVP

□ Solu-Cortef _____mg by □ PO/ □ IVP

□ Other:

Required Documentation:

□ Patient Demographics

□ Patient Insurance (med and pharm card copies, front and back)

□ Progress Notes/labs/imaging that indicate the diagnosis requiring the patient to receive Pemgarda

□ Other:

Patient height and weight:

Patient Height (cm): Patient Weight (kg):

Pemgarda Medication Order

- IV Dosing
  - □4500mg
  - □Other: _____
- Frequency
  - □ Once
  - □ Once every three months for one year (4 infusions)
  - □ Other: _____

AdditionalInstructions/Notes:

Patient IV Access

□ PIV

□ Use patient's SL/DL PICC, flush per protocol

□ Access/deaccess patient's Port, flush per protocol

*Imaging results of proper placement required for PICC/Port

Ordering Provider:

Signature: _____ Date: _____

Provider: _____ Phone: _____ Fax: _____

Best Contact Person in Office: _____ Phone: _____

Locations:

□ *Skokie, IL*: 4711 Golf Rd, Ste 900. P: 847-324-6800. F: 224-251-7141

□ *Libertyville, IL*: 1900 Hollister Dr, Ste 210. P: 847-324-6800. F: 224-251-7141

□ *Orland Park, IL:* 16612 107th Ct, Ste B. P: 847-324-6800. F: 224-251-7141

□ *Houston, TX*: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400