NORTH TEXAS INFUSION CENTERS

EUA: Pemgarda® (pemivibart) Order Form

Please include the following (required):
1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)

_____ _____
Patient Name **DOB**

_____ _____ _____
Weight **Allergies** **Patient Phone**

Diagnosis (include ICD10 codes)
☐ _____☐ Other (ICD-10 Code):_____

Prescription Orders: Pemgarda® (pemivibart)

Directions:
1. Give Pemgarda 4500mg over 60 minutes every 3 months.
2. Observe patient for 2 hours after infusion complete.

Pre-Medications:
☐ Acetaminophen 650mg PO ☐ Benadryl 25mg PO ☐ Benadryl 25mg PO
☐ Solu-Medrol 40mg IVP
☐ Other _____

Order will be good for one year (4 infusions) until specified otherwise.

_____
Provider Name **Phone** **Fax**

_____
Provider's signature **Date**

Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.
For any other questions please call (469) 480-9649.
Or visit us online at www.ntinfusioncenters.com