

Patient Status: ☐ NEW* ☐ CONTINUING

Next Due Date (if applicable) _____ Choose Location _____

*Include recent labs and last 2 office visit notes

Name _____ DOB _____
Phone _____ Other Phone _____
Email _____ SSN _____
Allergies _____ Weight _____ ☐ LBS ☐ Kg Gender ☐ M ☐ F

INSURANCE INFORMATION (Required)

Submit copies of the front and back of primary and/or secondary insurance cards with this referral

Physician Name _____ NPI# _____
License # _____ TIN# _____ DEA# _____
Address _____
City _____ State _____ Zip _____
Office Contact _____ Email _____
Phone _____ Fax _____

DIAGNOSIS INFORMATION:

Indication: Pre-exposure prophylaxis of coronavirus disease 2019 (COVID-19) 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

Diagnosis _____ ICD 10 _____

PEMGARDA DOSING

(adults and adolescents ≥ 12 years old AND ≥ 40 kg):

☐ Initial Dose: 4500 mg IV over 60 minutes

☐ Repeat Dose: 4500 mg IV every 3 months

Repeat dosing should be timed from the date of the most recent PEMGARDA dose

☐ Vital signs per HI protocol

☐ Anaphylaxis and hydration management per HI protocol

PRE-MEDICATIONS ☐ N/A

☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
☐ Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV (requires driver)
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 80mg ☐ 125mg IV
☐ Prednisone _____ mg PO
☐ Other _____

POST-MEDICATIONS ☐ N/A

☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
☐ Prednisone _____ mg PO
☐ Other _____

LABS

☐ CBC w/Diff ☐ Each Infusion ☐ Other Frequency (specify): _____
☐ CRP ☐ Each Infusion ☐ Other Frequency (specify): _____
☐ CMP ☐ Each Infusion ☐ Other Frequency (specify): _____
☐ ESR ☐ Each Infusion ☐ Other Frequency (specify): _____
☐ Hepatic Panel ☐ Each Infusion ☐ Other Frequency (specify): _____
☐ Renal Panel ☐ Each Infusion ☐ Other Frequency (specify): _____

Quantiferon TB Gold, annually, last completed (date): _____

Other (specify): _____

Provider Signature _____

Date _____

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Fax Referrals to: Kentucky (888) 977-0914 | New York (315) 457-4305 | Ohio (888) 977-0914 | Pennsylvania (724) 240-1586