PEMGARDA
(pemivibart) injection

Horizon Infusions

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)

Diphenhydrimine (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 _____

For new referrals, please include recent labs and last two office visit notes.

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