Pemivibart (Pemgarda)

Provider Order Form rev. 10/04/2024

Novella Infusion

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 IMMUNOCOMPRIMISED 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.