Pemivibart (Pemgarda)

Provider Order Form *rev. 11/06/26*

arbor infusion

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Mobile Phone Number:

Weight (lbs/kg): ☐ NKDA Allergies:

Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

Primary Diagnosis: ☑ Z29.89 Encounter for other specified prophylactic measures

Secondary Diagnosis: ☐ D84.821 Immunodeficiency due to drugs ☐ D83.9 Common variable immunodeficiency, unspecified

☐ D84.89 Other immunodeficiencies ☐ Z94.84 Stem cells transplant status

☐ **Other Diagnosis:**

PRIMARY MEDICATION ORDER

Pemivibart (Pemgarda) IV over 1 hour (use an in line 0.2 micron filter).
Flush with 0.9% sodium chloride at infusion completion

• Patient is required to stay for 2-hour observation period

• Refill for 12 months unless otherwise noted: _____

Dose / Frequency:

☐ 4500 mg administered as a single one-time intravenous infusion.

☐ 4500 mg administered as a single intravenous infusion approximately every 3 months.

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: pre-meds not typically indicated for Pemgarda

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ famotidine (Pepcid) 20 mg IV

☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV

☐ Other: _____

Dose: _____ Route: _____

NURSING

• Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

Ordering Provider (Print) **Provider Signature** **Provider NPI** **Date**

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zipcode:

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

☐ Arbor Infusion Fishers (317) 981-1772

☐ Arbor Infusion Carmel (317) 981-1772