REVITALIZE
INFUSION CENTER

Pemgarda™

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis Resulting in Patient Being Immunocompromised:

☐ Other:_____ ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis including:
  - Documentation qualifying patient as moderately-to-severely immunocompromised
- Relevant labs and tests including:
  - Recent (-) COVID Test
- Current Medication List

Height: _____

Weight: _____

Pemgarda (Pemivibart) Orders:

Infuse 4,500 mg intravenously over 1 hour every 3 months for ☐1 Dose or ☐ 2 Doses or ☐ Other:_____

Following the completion of the administration, monitor the patient for two hours (120 minutes)

Lab Orders: _____

Pre-Medication Orders: _____

*No pre-medications are recommended based on the manufacturer's EUA

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

Please fax the completed order form an all other requested information to: 601-714-1569

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus