Pemgarda (pemivibart)

MIC | METRO INFUSION CENTER

Infusion Office Preference: _____

PATIENT INFORMATION		
Date:	Patient Name:	DOB:
☐ NKDA Allergies:		

PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		

DIAGNOSIS /ICD 10
☐ Moderate to severe immune compromise d/t a medical condition or receipt of immunosuppressive medications or treatments **and** are unlikely to mount an adequate immune response to COVID-19 vaccination **and**: Not currently infected with SARS-CoV-2 and who have not had a known recent exposure to an individual with SARS-CoV-2 **ICD-10 Code (required): _____ ICD-10 Description: _____**

REQUIRED DOCUMENTATION/Testing	
☐ This signed order form by the provider ☐ Patient demographics AND insurance information	☐ Clinical/Progress notes supporting diagnosis above ☐ Verification that patient has not had severe hypersensitivity reaction to a COVID-19 vaccine

MEDICATION ORDERS
☐ 4500mg iv one-time infusion over 60 minutes using 0.2micron inline filter
☐ 4500mg iv every 3 months over 60 minutes using 0.2micron inline filter
Patients must be monitored for 2 hours after the infusion.

Provider Name (Print) **Physician Signature:** **Date:**

Fax referral to 866-507-1164 or email to MICreferral@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

06/30/25