



Pemgarda Order Form

Patient Name: _____ DOB: _____

Phone: _____ Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Sex: _____ Height: _____ Weight: _____ Allergies: _____

DIAGNOSIS:

Other: _____ ICD-10: _____

Other: _____ ICD-10: _____

ORDER FOR PEMGARDA (PEMIVIBART):

4500 mg IV every 3 months x 1 year

Other Dose: _____ Frequency: _____ x 1 year

PRE-MEDICATIONS:

Acetaminophen 650mg PO

Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO

Hydrocortisone 100mg IV or Methylprednisolone 125mg IV

Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

Nevada Infusion Hypersensitivity Reaction Order Set

Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line

FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml

NURSING: Per Nevada Infusion

LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI: _____

Physician Signature: _____ Date: _____

Point of Contact: _____ Phone: _____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **



Nevada Infusion

Reno Location - 5401 Longley Lane, Suite 34, Reno, NV 89511

Carson Location - 180 E. Winnie Lane, Carson City, NV, 89706

PH: 775-453-0667 | Fax: 775-470-8478

Patient Name: _____ DOB: _____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

- Signed provider orders (page 1)
- Patient demographic and insurance information
- Patient's current medication list
- Supporting recent clinical notes and H&P (to support primary diagnosis)
- Supporting documentation to include past tried and/or failed therapies
- Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
- Include labs and/or test results to support diagnosis
- Other medical necessity: _____

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